The Rhode Island Global Consumer Choice Compact Concept Paper

Department of Human Services
Gary D. Alexander, Director

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The Global Consumer Choice Compact Medicaid Reform Plan: Redesigning Medicaid for the Future

Problem Statement

Medicaid is the largest expenditure in the State of Rhode Island's annual budget. If current trends continue, the Rhode Island Medicaid program will grow at a projected rate of approximately 7% per year through 2013. Today, over half of each new revenue dollar the State generates is financing the Medicaid program. As this rate of expenditure growth is unsustainable, decision-makers are confronted with difficult choices about how to contain rising Medicaid costs while preserving health coverage and services for individuals and families with the greatest need.

As of this writing, Rhode Island faces a budget shortfall of $384 million for State Fiscal Year (SFY) 2009. As the largest segment of the State budget, the Medicaid program has been targeted for a series of significant reductions despite several successful efforts over the last few years to contain rising program costs and increase the cost-effectiveness of services. For example, the State has for a number of years implemented a variety of strategies to improve the quality of services, allow for more choices, rebalance the service delivery system, and manage care. Though these efforts have moved Rhode Island Medicaid in the right direction, the State has not been able to fully reform its Medicaid program to be "person-centered" and to promote competition, prevention, wellness, personal responsibility, choice, consumer empowerment and independence.

Indeed, several exhaustive reviews[1] of the Rhode Island Medicaid program conducted over the last year found the following:

- The Medicaid system is provider -driven and not person-centered;
- Medicaid beneficiaries have limited choices over the services they receive;
- There is a pervasive institutional bias in the long-term care side of service delivery;
- Long-term care services can be provided in community-based settings often at a lower cost, and with a greater quality of life;
- The Medicaid program does not encourage and reward prevention, wellness and disease management;
- In many program areas, payments and reimbursement methodologies are not linked to quality and performance;
- The information beneficiaries need to make reasoned choices about their health care is not readily accessible or transparent;
- Too many children are receiving services in high-cost residential care and/or group home settings, rather than less restrictive settings in their communities;
- The range of service setting choices open to adults with chronic illnesses and disabling conditions has been both dictated and limited by providers;
- Services for individuals with behavioral health care needs are fragmented and frequently do not treat the person as a whole nor involve family members;

[1] See finding of the RI Executive Office of Health and Human Services. The Future of Medicaid, October 2007 available at: ohhs.ri.gov.

- Some individuals and families need assistance in making decisions about the most appropriate array of services to assure there are adequate supports;
- There is no meaningful competition among providers;
- Rhode Island has one of the highest rates of elders in nursing facilities in the nation; and
- Personal responsibility is lacking for a number of important health-related decisions.

The challenges posed by these findings and the State's fiscal crisis have created the opportunity for Rhode Island to pursue meaningful and lasting Medicaid reform. Toward this end, the Global Consumer Choice Compact waiver outlined in this document calls for a fundamental shift in the focus, financing and operations of the Rhode Island I Medicaid Program. The next section outlines the guiding principles of Medicaid reform that established both the infrastructure and goals of this waiver.

Guiding Principles for Medicaid Reform:

- **Consumer Empowerment and Choice**. If consumers have more information about and control over their health care and community support options, they will make more reasoned and cost-effective choices about their health, especially if their good decision-making is rewarded.

- **Personal Responsibility**. Armed with easy to understand and accurate information, in some cases a fiscal intermediary, and adequate access to needed services, consumers will become better shoppers for themselves and their families. Ultimately, improved technology allowing consumers and providers to access and evaluate health information will play an important role in both promoting and measuring the impact of this approach. Additionally, Health Savings Accounts can be used to encourage personal responsibility, and drive consumer choice and empowerment.

- **Community-based care solutions**. Rhode Island is committed to transitioning beneficiaries from institutional settings back into the community as well as to assisting more people to remain in the community who require long-term care or residential services. Rhode Island's program re-design is based on the assumption that community-based care services will result in improved health, quality of life and more cost-effective care.

- **Prevention, Wellness and Independence**. The Medicaid program must enable consumers to receive individualized health care that is outcomes-oriented, focused on prevention, recovery and retaining/maintaining independence.

- **Competition.** Competition between health care providers is necessary to ensure best value purchasing, leverage resources and create opportunities for improving service quality and performance.

- **Pay for Performance**. Medicaid purchasing and payment methods will encourage and reward service quality and cost-effectiveness by tying reimbursements to physicians, dentists, hospitals, and other major providers to common, evidence-base quality performance measures, including patient satisfaction.

- **Improved Technology as a key ingredient** The current technology must be revamped to take advantage of recent innovations and advances that assist decision makers, consumers and providers to make informed and cost-effective decisions regarding health care.

Merging Principles and Practice: The Right Services, at the Right Time, and in the Right Setting

Translating the principles of reform into concrete practices requires that the State fundamentally redesign the way Medicaid funded services and programs are organized, financed, and delivered. The challenge for the State, thus, is to change both prevailing conceptions and expectations about the Medicaid program as well the way it is structured.

Over the years, the Rhode Island Medicaid program has been subjected to a host of incremental changes that have fragmented the organization, financing and delivery of Medicaid services. The system is now difficult for consumers to navigate and understand. Rhode Island's Medicaid Program is prone to inefficiencies, most of which are related to type of service and care setting. For example, RIte Care enrollees are far too often utilizing emergency departments (EDs) for primary care services; adults with disabilities, particularly those with serious behavioral health conditions, are also overly reliant on EDs for their care. High cost institutional and residential settings provide a disproportionate share of Medicaid funded long-term care for frail elders, adults with developmental disabilities and catastrophic illnesses and children with serious emotional disturbances.

Each of the State agencies responsible for administering Medicaid funded services to these populations has endeavored to decrease reliance on costly service venues. For the most part, these piecemeal efforts have only succeeded at the margins. As a result, a significant percentage of Medicaid expenditures continue to be spent serving beneficiaries in these high cost settings. To re-orient the Medicaid program to incorporate the principles of reform and shift the bias away from high cost and institutionally-based forms of care, the State's health and human services agencies have collaborated to develop a broader view – a view that focuses on the "person" and the full continuum of care options that can and should be available to the beneficiary across the lifecycle.

On the long-term care side, the State's Medicaid reform proposal seeks to rebalance the system away from high cost institutional venues and toward home and community based settings – for example, shared living arrangements, assisted living and at-home care. Thus, translating principles into practice on the long-term care side requires the centralization of certain programmatic functions (i.e., long-term care intake, assessment and referral), the reconfiguration of others (i.e., combining home and community-based waivers), and the integration of still others (i.e., braiding long-term care funding streams). Under this waiver decisions about the type of service and setting will be determined in conjunction with the beneficiary and his or her family and will be based on an assessment of level of care needs and personal preferences instead of population or funding stream.

To further promote the principles of reform, existing support systems that foster self-determination and independence will be drawn upon and strengthened wherever possible. Personal choice is critical and an important factor that will affect the success of this effort. Accordingly, every individual and/or family (or guardian if available) must understand the full range of support options before deciding which is best for their unique situation. To make that choice meaningful, the State must expand the range of community- based service options open to beneficiaries beyond existing supports whenever and wherever feasible. Built into the implementation of the redesigned system is a centralized Assessment and Care Coordination Unit. One of the

chief responsibilities of this unit is to continuously educate, the public about various service options, to ensure that those seeking alternative service options and supports make informed decisions about their own health care.

All populations covered under Rhode Island Medicaid will be enrolled in a managed care plan or primary care case management practice. This care management is a pivotal element of the Medicaid reform initiative, as it will provide the first line of defense against the over-reliance on high cost services and the principal source of the health services necessary to maintain, attain, or optimize the health and wellness of beneficiaries. The mandatory care management of each beneficiary's medical care will serve as the nexus for coordinating and/or integrating services across the health care continuum as an individual's needs change over lifetime.

On the acute care side, the State must ensure both in principle and in practice that beneficiaries take greater responsibility for their own health care, by contributing to the costs of coverage to the full extent their income allows and paying a premium for services provided in high cost (i.e. ED) rather than appropriate (i.e., primary care provider's office) settings. Certain beneficiaries will also be required to "take charge" of their health through health opportunity accounts that reward wellness, prevention and health conscious lifestyle choices. Moreover, all parties involved in the acute care health service delivery system – providers, third-party payers, and Medicaid – will be required along with beneficiaries to pay their "fair share" of the costs for coverage.

Ensuring that every beneficiary has access to the right services in the right settings requires that the State change the way services are purchased. Every Medicaid dollar the State spends must achieve the best health outcome. Any dollars saved from expanding personal responsibility and implementing a fair share approach must be reinvested in the Medicaid program to further the principles of reform. Additionally, the model of value based or "smart" purchasing, shall be expanded so that increased competition can yield not only the best price, but also improved capacity and performance. Toward this end, the State is committed to restructuring how it purchases and pays for services, particularly on the long-term care side. This will result in a new and better market that address beneficiary needs, promotes greater quality and transparency of cost.

In sum, Rhode Island's Medicaid reform proposal provides the framework for providing high quality and cost effective services that builds upon the positive gains made in the program over the last ten years and extends their reach further. From the administrative and financing perspective, the proposal presented here establishes a new state-federal compact that provides flexibility in exchange for federal budgetary certainty.

Rhode Island is requesting that CMS grant the State a defined federal financial contribution in exchange for increased flexibility in designing programs to better meet the needs of the covered population by redirecting savings achieved from directing individuals from high cost care settings to lower less restrictive cost services. In exchange for the increased flexibility and potential to capture such savings, the Rhode Island also assumes a degree of risk regarding caseload and inflation trends. Overall this proposed compact would provide Rhode Island with the tools necessary to address its beneficiary's needs in a holistic and person-centered manner, while providing the flexibility to adapt to change

More specifically, under the proposed compact, Rhode Island will operate its entire Medicaid program under a single waiver demonstration over the next five years. All Medicaid funded services on the continuum of care – from preventative and acute to long-term and end-of life-care – will be organized, financed and delivered through this proposed demonstration. Accordingly, Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, the 1915(b) Dental Waiver and its various Section 1915 Home and Community Based Services waivers will become a part of the Global Consumer Choice Compact Demonstration. Additionally, on-going initiatives that further the Compact's principles will also be incorporated into the demonstration. For example, the State's Medicaid Transformation and CHOICES MMIS Module initiatives along with a statewide health information exchange under construction will provide strategic

resources that will assist in implementation of the demonstration. The State's Real Choices grant and the Rhode Island Perry-Sullivan Act [2]of 2006 -- both of which are targeted at long-term care system reform – will guide consumer and provider outreach and efforts to change existing service markets and build new ones. (See Appendix I for a full list of these initiatives.)

It is critical to note that although the most significant changes proposed for the Rhode Island Medicaid program are on the long-term care side, the demonstration will provide all the populations the State covers with the incentives and opportunity to take greater responsibility for their health care choices. More importantly, the person-centered approach to service design and delivery will extend to every beneficiary; irrespective of age, care needs, or basis of eligibility. Every State agency that collaborated on the design of the demonstration is committed to ensuring no less.

Rhode Island, through this new compact, will commit to controlling the cost of the Medicaid program, while preserving the gains achieved; streamlining operations; and undertaking innovative reforms that stress private-public partnerships, prevention, wellness, personal responsibility and evidence-based practices. With this compact Rhode Island will ensure that every dollar is spent prudently and wisely and will be able to restore the Medicaid program's fiscal solvency and sustainability. Without this compact Rhode Island fears that it will not be able to expand its quality initiatives and may be faced with further elimination of vital programs.

The following sections describe the central components of the proposed waiver and explain how the State will operate its Medicaid program under the new compact. Particular emphasis is placed on those areas where implementation of the demonstration will have the greatest impact.

Waiver Components

The purpose of this Section 1115 waiver request is to afford the State the flexibility to transform principle into practice, as outlined above, through three components: (1) Rebalancing the long-term care system, (2) instituting mandatory care management across programs and populations, and (3) pursuing smart "selective" purchasing strategies in several key, high cost areas.

I. Rebalancing the Long Term Care System and De-Institutionalization across the Spectrum

Rhode Island's long-term care system is heavily based on nursing home care, residential care and high-end services in restrictive and costly venues. Through this change initiative, the State of Rhode Island proposes to rebalance the system in favor of community-based care by diverting prospective admissions, transitioning beneficiaries whenever appropriate and feasible and developing care setting and service alternatives. The goal of this facet of reform is to move towards a 50/50 split in the dollars spent for people being served in institutional and residential high-end placements versus less restrictive, but care appropriate settings in the community by 2013.

This Medicaid Reform package is based upon a philosophy of service delivery that encourages individual self-determination, family involvement, interagency collaboration, and individual choice through the provision of

[2] The Perry/Sullivan Long-Term Care Service and Finance Reform Act (Chapter 40-8.9-Sections 1-6),

highly specialized and individually tailored home-based services. The State is committed to ensuring that individuals with severe behavioral, physical, or developmental disabilities have the opportunity to live safe and healthful lives by offering a wide range of supportive services in an array of community-based settings regardless of the complexity of their medical condition, the severity of their developmental disability, or the challenges of their behavior. By delivering Medicaid funded services and supports in less costly and less restrictive community settings, thousands of children, adolescents and adults may be able to curtail, delay or in some cases, avoid completely lengthy stays in residential treatment facilities, juvenile detention centers, psychiatric facilities, and/or intermediate care or skilled nursing facilities.

The Medicaid plan endorses and encourages the self-determination of all individuals receiving services, and looks to draw on natural support systems wherever possible. Through formal and structured interagency collaboration in determining the needs for and scope of services, the entire community-based service delivery system for all individuals will improve, and ultimately, ensure that each person receives the best possible combination of age-appropriate services and supports suited to his or her needs.

The Proposed LTC System

To achieve balance in Rhode Island's long-term care system, the paradigm must shift to eliminate the existing institutional bias in long-term care and create the infrastructure for a person-centered system that provides a broad array of community-based care choices. The Medicaid reform initiative proposes to achieve this shift by reducing reliance on high-end institutional placements, expanding available and effective community-based services, and empowering consumers to determine the most appropriate setting for their care

Level of Care and Service Determinations

Among the most significant changes to be implemented under this proposed demonstration is the plan to replace the current single level of care definition within each of its 1915(c) Home and Community- Based Service (HCBS) waivers with a three-tier level of care determination process. This is essential to assure that every beneficiary requiring long-term care is able to access the right services in the most appropriate setting regardless of the basis of eligibility for services.

To replace the current single level of care determination, Rhode Island will draw on elements from the successful long-term care initiatives of other states that utilize a system for determining the scope of necessary services that is tied to an assessment of the need for an institutional level of care, i.e., nursing facility, ICFMR, and hospital. The service levels are as follows:

- The highest level of care will be reserved for nursing home and residential treatment facilities. Beneficiaries meeting this level of care will also have the option to choose community-based care, including an extensive menu of services and supports.

- A high level of care will allow the beneficiary access to an array of community-based core services, including but not limited to shared living, assisted living and home care services and supports.

- A preventive level of care will enable beneficiaries to receive services targeted at preventing re-admissions or reducing lengths of stay. Funding will be established for a service package that will include such items as homemaker services, home modifications or physical therapy services. Access to these services will be based on availability, rather than guaranteed.

The matrix below shows which types of services are available to beneficiaries within these levels of care:

Medicaid Reform: LTC Proposed Level of Care and Service Option Matrix		
Highest Nursing Home Level of Care (Access to Nursing Facilities and all Community-Based Services)	**Highest Hospital Level of Care** (Access to Hospital, Group Homes, Residential Treatment Centers and all Community-Based Services)	**Highest Intermediate Care Facilities Mentally Retarded Level of Care** (Access to ICFMR, Group Homes and all Community Based Services)
High Nursing Home Level of Care (Access to Core and Preventive Community-Based Services)	**High Hospital Level of Care** (Access to Core and Preventive Community-Based Services)	**High Intermediate Care Facilities Mentally Retarded Level of Care** (Access to Core and Preventive Community-Based Services)
Preventive Nursing Home Level of Care (Access to Preventive Community-Based Services)	**Preventive Hospital Level of Care** (Access to Preventive Community-Based Services)	**Preventive Intermediate Care Facilities Mentally Retarded Level of Care** (Access to Preventive Community-Based Services)

Under this proposal, beneficiaries at each level will have access to core and preventive services. Core services will be available to the highest level of care group at all times and to the high level of care group to the extent funding is available. Preventive services will be available to the highest level of care group at all times and to the high and preventive level of care group as long as funding is available.

The Core and Preventive Community-based Services are identified below:

Medicaid Reform: LTC Core and Preventive Services		
Core Services		**Preventive Services**
Personal Care Services	Service Coordination	Homemaker Services
Home Health Services	Assisted Living	Moderate Home Modifications
Home Modifications	Medication Management	Respite
Companion Services	Meal on Wheels	Physical Therapy Evaluations
Supportive Employment	Adult Day Care	
Personal Emergency Response Systems	Shared Living	
	Assistive Devices	
Adult Day Programs		

To ensure beneficiaries have access to the appropriate services in the appropriate setting, the State is establishing a centralized unit, explained in greater detail below, to streamline the intake and assessment processes and provides beneficiaries and their families with clear, concise and accurate information about their care options. State Medicaid staff will also be available within hospitals to assist in the planning and execution of appropriate discharges and to ensure beneficiaries have and fully understand their choices for care setting.

Additionally, Medicaid staff will be available in residential care settings to assist beneficiaries and their families in instances when a transition back into the community is an appropriate option. Training will also be provided to discharge planners across settings.

The Assessment and Coordination Unit

The establishment of an interagency long-term care Assessment and Coordination Unit (ACU), under the umbrella of the Office of Health and Human Services, is critical to achieving the State's goal to rebalance the long-term care system. As part of the eligibility determination process for Long-Term Care or Community Support Services, Medicaid beneficiaries will receive both a comprehensive assessment and individualized counseling to assist them in making optimal choices through the ACU.

The establishment of the ACU will:

- Centralize decision-making;
- Support individuals with an enhanced menu of services in the least restrictive setting, whenever appropriate; and
- Afford a standard of fiscal responsibility for the State of Rhode Island that will ensure a person-centered and fiscally solvent system of long-term care for generations to come.

Medicaid beneficiaries (both new and existing beneficiaries) who may require either residential services (nursing home/ group homes/ child residential) or community support services will also be provided with a full assessment to determine their level of care and services needs by the ACU, in accordance with the level of care matrix presented above.

The State plans to develop an algorithm to assist the ACU in making determinations of care and service needs that is tied into information provided through the CHOICES MMIS Module now under development as well as to the State's health information exchange system. As noted earlier, both of these efforts are being financed in whole or in part with Medicaid grants and, as such, will be adapted to assist in achieving the goals of the reform initiative.

The ACU will be staffed by State employees (for those cases currently managed by state workers) and contractors (for those cases currently managed by contractors). Centralizing responsibility for determining the scope of care and service level in a single interagency entity is designed specifically to shift the loci of decision-making away from providers and to beneficiaries and their families. As such, the ACU will not only assist in drawing a clearer delineation between the payers and providers in the design and implementation of a service plan, but it will also further the long-range objective of reform to break the strong-hold providers have over the scope of services beneficiaries receive.

As is explained in greater detail later in this document, the majority of Medicaid beneficiaries will be required to enroll in an approved managed care plan or a primary care case management model (PCCM) that will ensure that their medical care is coordinated and cost-effective. One of the roles of the ACU is assisting beneficiaries in determining which of these care management options best suits their care management needs and in establishing coordination between the care manager, service provider or beneficiary. Initially, the care management requirement excludes Medicaid beneficiaries who are also Medicare beneficiaries as well as those who have qualified employer-sponsored health insurance. Over the course of the waiver, the State will be developing care management options that will extend to dually eligible beneficiaries through a Special Needs Plan (SNP) or Medicaid-Medicare waiver

Another role of the ACU will be providing timely and accurate information about care options. The State will be implementing a choice-counseling program that will provide beneficiaries with the information necessary to make educated choices about their care. Accurate information about prices, utilization and quality will be available routinely to ensure transparency and ease of access. To both enhance choice and promote personal responsibility, beneficiaries also will be provided with health reports that indicate how they have spent their health care dollars so they can evaluate health outcomes on their own.

The Assessment and Coordination Unit will be responsible for:

- Conducting assessments;
- Determining a level of care;
- Developing Service Plans;
- Pricing a service budget and developing a voucher when appropriate;
- Making referrals to appropriate settings;
- Maintaining a component that trains and educates consumers, discharge planners and providers; tracks utilization; monitors outcomes; and reviews service/care plan changes;
- Providing interdisciplinary high cost case reviews; and
- Choice counseling.

As an extension of the eligibility determination process, population-specific components of the ACU will continue to be managed by the appropriate State agency. Universal functions such as training, staff meetings, stakeholder education, assessment tool reviews, and outreach initiatives will be coordinated by OHHS. Contracted community-based providers will continue to provide ongoing case management for beneficiaries with periodic reviews by the Assessment and Coordination Unit. OHHS will have the option to issue an RFP to solicit vendors to support the training of community – based providers and to assist in the monitoring of service plans.

Although the establishment of the ACU does not require federal waiver approval, the State is seeking authorization to enable the unit to use the assessments as the basis for establishing individual budgets, power accounts, and limiting accessing to certain services. Approval of this facet of the ACU is not only critical for achieving the goals of reform, but for the overall success of the demonstration proposed as well.

Service Delivery System

Institutional and community-based long-term care services will be delivered in three ways:

- Fee-for-service: Beneficiaries will be able to access long-term care services in the same way that services are accessed today, through a fee-for-service system. Under this system, a beneficiary can choose an agency or a provider from whom he/she receives services. That agency or provider bills the Medicaid agency for services delivered.

- Self-direction: Beneficiaries will also have the option to purchase personal assistance services (including, but not limited to, aid in daily living tasks such as bathing, dressing, toileting, meal preparation) through a self-direction option. Under this option, beneficiaries will work with the ACU to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island's 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Rhode Island's plan to implement an expanded self-directed service delivery option is explained in greater detail in Appendix II.

- Limited Funding: Beneficiaries assessed to be at the high level of care will have access to core and preventive community-based services (homemaker services; moderate home modifications; respite; and physical therapy evaluations) on a limited basis. Beneficiaries assessed at the preventive level of care will have access to preventive community-based services on a limited basis. These services will be available to individuals at these levels of care based on available funding. The State will determine if the limits will be set on a service basis or an individual basis.

Expanding Capacity

The success of the Medicaid reform initiative for Rhode Islanders will depend, in large part, on improving the availability and effectiveness of community-based service providers and programs. With the onset of an ambitious nursing home and residential care diversion and transition effort, Rhode Islanders returning to the community and remaining in the community will present with complex medical, social, functional, and/or cognitive needs. The State's ability to transform the guiding principles of Medicaid reform into practice and ensure every beneficiary receives the right services, at the right time and in the right setting, is thus contingent on its ability to make the services required to meet these needs readily accessible.

Accordingly, as part of the effort to meet the anticipated increased demand for community services, the State has designed a comprehensive, detailed plan, with assessment and care coordination at its core, for the expansion of existing programs and services and the introduction of innovative and flexible community supports. This plan will provide a mechanism to build upon and support the critical principles articulated in the Perry/Sullivan Long-Term Care Service and Finance Reform Act (R.I. Gen. Laws sections 40-8.9-1 through 6) (Perry-Sullivan Act). The Perry-Sullivan Act also provides the Rhode Island Department of Human Services with the statutory authority to submit requests for waivers, demonstration projects, grants and state plan amendments or regulations that may be considered necessary and appropriate to support its general statutory purpose. These objectives also dovetail with several of the central tasks currently underway as part of the State's Real Choices LTC Grant.

Appendix III provides an in-depth analysis of shared living arrangements, one of the various forms of residential services that will be the focus of the State's efforts at capacity building and investment in community-based service options.

In general, the essential instruments the State will be using in the expansion process/capacity building process include:

- Expanding the flexibility of community providers to include programs such as adult day services and home delivered meals on weekends and holidays;

- ❖ Broadening the service categories for Medicaid reimbursement to include such services as medication management, flexible transportation, fall prevention training, and other services that will be provided in supportive housing options like supervised apartments and shared living;

- ❖ Increasing the availability of community service providers through a combination of rate increases, performance and business redesign incentives, credentialing standards, and by supporting of training and education opportunities;

- ❖ Expanding adult day service options by raising rates and tying them to performance i.e., expanding operating hours to 7 days, developing greater capacity, and broadening services to include higher levels of acuity);

- ❖ Expanding the use of various self-directed care models available to beneficiaries including cash& counseling, service vouchers, money follows the person, etc.;

- ❖ Developing transitional support services;

- ❖ Adding more and a greater variety of outlets for counseling beneficiaries about their community-based options by including hospitals, nursing homes, and physicians' offices;

- ❖ Providing financial incentives/rewards to health care professionals who promote and utilize community-based services for their patients, when appropriate;

- ❖ Supporting State-funded programs that serve a Medicaid enrollment diversion function – e.g., --which maintain beneficiaries in the community and delay admissions to institutionally-based or high cost residential care;

- ❖ Building public investment and participation through provider/advocate meetings and consumer focus groups to ensure service oversight and quality; and

- ❖ Coordinating with Faith Based Organizations to perform chore services (e.g. cutting grass or shoveling snow; pharmacy and grocery deliveries; budget management, etc.) by creating a stable of volunteers to provide these services to beneficiaries living in the community.

Rate Restructuring

A major obstacle to the goal of expanding capacity in the community-based services system is the inability of providers to compete for qualified workers. Medicaid's historically low payment rates and reimbursement methods have only served to exacerbate this problem.

A cost finding review, pursuant to "Perry-Sullivan", is currently underway to determine the extent to which State rates cover adequately the true cost of service delivery. The goal of this review is to bring both clarity and transparency to the rate setting and payment structure, particularly for those services in which there is the greatest demand. To further the goals of reform, the State will also be looking at this review and the results of a comprehensive mapping of resources to determine where the service gaps exist in the continuum of care and how the State might use incentives and smart purchasing to drive the market in these areas. These tasks are being performed as part of the State's Real Choices grant. At a minimum, the State is seeking approval to reinvest a portion of any savings derived from Medicaid reform initiatives that reduce reliance on high cost care venues to broaden the range of available service setting choices.

An additional challenge to rebalancing the system on the financing side is that federal matching funds are not uniformly available for many of the expenses (rental deposit, utility connection costs, minor home modifications, etc.) attendant to transitioning beneficiaries back into the community. As part of this demonstration, the State proposes to utilize all of the Medicaid options other states have used to cover these transition expenses -- i.e., administrative expenditures, waiver authority – as well as the following:

- An immediate *prospective* base adjustment to rates paid for homemaker, adult day services, and personal care (home health aide) services across all departments and programs, of an amount between five (5%) and ten (10%) of the existing standard or average rate, contingent upon a demonstrated increase in the state-funded caseload of ten per cent (10%) by June 30, 2009;

- Development of targeted rate increments for all of the subject services to encourage service specialization and scheduling accommodations, including, but not limited to, medication and pain management, wound management, certified Alzheimer's Syndrome treatment and support programs, and shift differentials for night and week-end services;

- Development of a rate-setting methodology for these community-based services that assures coverage of the base cost of service delivery as well as reasonable coverage of changes in cost caused by inflation – particularly wage inflation;

- Establishment of a fund to pay for the non-Medicaid reimbursable expenses necessary to transition residents back to the community not to exceed an annual or per person amount; and

- Extend the developed rate or rate structure for each service where applicable to Medicaid waiver services and the associated State- only programs.

The State's goal is to provide sufficient incentives to increase the number of approved community-based providers and is committed to expanding the range of related service options for elders and adults with disabilities, as well as for children with special and/or therapeutic needs. Absent a sustained effort to increase the availability and range of these options, reliance on high cost service venues will continue.

Transitioning and Diverting Individuals into the Community

Over the next few years Rhode Island will be transitioning and diverting hundreds of its citizens into lesser restrictive settings. In general, the State is committed to ensuring the beneficiaries and their families are involved in the process of transition planning and are aware fully of the options open to them. Each State agency responsible for the populations targeted for transition/diversion faces a unique set of challenges. For example, as the State has succeeded in transitioning over a hundred elders from the nursing home setting just in the last year, the ACU's capacity to drive the diversion plan now under development is critical. The principal challenge for transitioning children is providing the right mix of incentives to vendors that will ensure beneficiaries moved from high cost venues to family and community settings have ready access to necessary services. Equally important in this arena, is expanding waiver eligibility to families who currently voluntarily relinquish custody of their children for placement in substitute care so necessary Medicaid funded services can be accessed. Similar challenges face the State in moving beneficiaries with developmental disabilities and serious mental illness from intensive residential and institutional settings. Often, these are the only care settings covered by Medicaid and/or the sole care venues that provide the services needed in a secure setting. Full details about how the State plans to ensure a smooth transition for each population is explained in greater detail in Appendix IV.

Eligibility

Besides streamlining the eligibility and intake process, Rhode Island is considering making changes to a number of policies pertaining to eligibility and financial requirements. The eligibility and financial requirements for Medicaid long-term care and community support services will be modified to reduce the bias toward institutional placements and broaden access:

Some of the concepts under consideration are:

- Applying the same financial criteria across programs and populations;

- Allowing for an income disregard for living expenses. The current allowance of $758 is not sufficient to cover the actual living expenses of beneficiaries who choose to obtain services in the community. The enhanced disregard will only be available to individuals in need of a high level of care. In addition to the $758, the enhanced disregard will include an additional $100 for electric utilities, $100 for heat, and $200 for rent/mortgage payment, thus allowing qualified beneficiaries to keep about $1158 a month;

- Implementing presumptive eligibility so that individuals can received needed home and community based services immediately while the financial eligibility determination is being determined;

- Implementing a Long-Term Care Partnership Program;

- Offering individuals who purchase reverse mortgages the same set of incentives available to those participating in the Long-Term Care Partnership Program;

- Treating individuals over the age of 65 who are not otherwise Medicaid eligible and who are in need of personal care services, at risk for institutional placement and income less that $20,000 a year to be Medicaid eligible only for a limited home and community based service package;

- Enabling certain children who are not otherwise Medicaid eligible to qualify for certain home and community-based care service as alternative to requiring parent's to voluntary give the State custody so they can be placed in substitute care, residing in the community and who are in need of residential services to be found Medicaid eligible; and

- Enabling the State to treat Skilled Nursing Facilities (SNF) services as a community Medicaid benefit. Currently long-term care eligibility rules are applied to individuals in need of SNF services. The Stare would like to eliminate the necessity of applying for LTC and have individuals in need of these services apply as community medical assistance beneficiaries

II. Care Management: A Medical Home for Every Medicaid Beneficiary

One of the central goals of the Rhode Island Medicaid reform initiative is to shift the focus in the program to make it "person-centered." Under the proposed demonstration, doing so will be achieved by requiring that each beneficiary has:

- Access to appropriate services and an accountable medical home that provides support in coordinating/managing services and assistance in system navigation; and

- ❖ Personal responsibility for decisions about their care and has access to the information required to make reasoned care choices.

For the purposes of Medicaid reform and the proposed demonstration, a person-centered medical home provides comprehensive primary care that facilitates partnerships between beneficiaries, their personal physicians, other healthcare professionals and community providers and, when appropriate, the beneficiary's family. The State has developed a two-prong strategy designed to further this goal that includes implementing mandatory care management and power accounts.

Managing Care

The State proposes to require all Medicaid beneficiaries without third party healthcare coverage to enroll in a managed care plan or in a primary care case management (PCCM) plan. Children and families, including children with special health care needs and children in substitute care, will be required to enroll in one of several RIte Care managed care plans or RIte Share, the State's premium assistance program. Elders and Adults with disabilities will have the choice of enrolling in the one of the Rhody Health Partners managed health plans, PACE or a Connect Care PCCM. The options are outlined as follows

Care Management Options By Populations		
	Health Plan	**PCCM**
Beneficiaries Served:		
• Children &Families • Children with Special Needs • Children in Substitute Care	• RIte Care Plans • RIte Share	Under Design – May include: • Connect Care Plus (for high cost cases)
• Elders • Adults with Disabilities	• Rhody Health Partners • PACE	• Connect Care Choice • Connect Care Plus (for high cost cases)
The dually eligible population (Medicare/Medicaid) will have the option to enroll in a Special Needs Plan or PACE		

The State will utilize contracts with these entities to promote personal responsibility, prevention, and wellness by building on, re-engineering and expanding upon long established and newly developed program options, including RIte Care, Connect Care Choice and Rhody Health Partners. In combination, these initiatives help fulfill the commitment for cost effective, person centered care management is in place for all Medicaid beneficiaries.

Indeed, under the mandatory system, every Medicaid beneficiary will have a medical home and will have access to services designed to meet their needs as well as to a level of care coordination that might otherwise be unavailable, particularly for these beneficiaries who are living on their own in the community. It is important to stress here that though care management systems are by their very nature acute care oriented (i.e., emphasizes

primary care, preventive, and wellness), there will be a nexus to the long-term care system through the ACU and community case managers. Providing a medical home will also ensure that health coverage and services are more outcomes based. For example, implementing care management instruments across populations increases the opportunities significantly for more efficient monitoring of access and quality, greater use and efficacy of performance-based payment incentives and improved cost effectiveness through value -based purchasing.

Mandatory Care Management for Adults

The RI Department of Human Services (DHS) was authorized by the Rhode Island General Assembly to implement a system of health care delivery through a voluntary managed care health system. DHS has developed two program options for adults to enhance cost effectiveness, care coordination, and improve quality of care. These are Connect Care Choice and Rhody Health Partners. Rhody Health Partners combines with Connect Care Choice to provide two quality options for this population. To date, enrollment in one of these two options has been voluntary and some segment of the population still remains without care coordination and care management. Under the proposed demonstration, enrollment will become mandatory. Choice Counseling will be provided at the time of application for eligibility to assist individuals and families in evaluating their care management options.

Through the Rhody Health Partners option, beneficiaries can enroll in a participating health plan. The eligible population is Medicaid eligible community based non-dual adults and will include beneficiaries residing in supportive housing settings – e.g., group homes and assisted living. Initial enrollment in this optional managed care program began on April 1, 2008. Participating health plans are United Health Care of New England and Neighborhood Health Plan of Rhode Island.

Primary Care Case Management: Connect Care Choice

The immediate goal of the Connect Care Choice model of delivery is to assemble Primary Care / Nurse Case Management (PCCM) Networks from existing "Best Practices" and settings of care that have adopted the Chronic Care Model and will provide a medical home, nurse case management, primary and preventative care while encouraging self management supports and education. The design of this system of health care delivery is holistic in approach to achieve and maintain wellness, and to improve access to primary and specialty care.

The goal is to have the adult Medicaid members achieve independence in the community with the necessary medical and social supports. The provider networks for the Connect Care Choice model will be developed based on practices in a variety of settings that have adopted the chronic care model through participation in the Rhode Island Chronic Care Collaborative, a Robert Wood Johnson funded initiative partnering with the DOH Diabetes Prevention and Control Program, facilitated by the Quality Partners of Rhode Island. These practices include all settings of care; private group practice, community health centers and hospital based ambulatory clinics. Additionally standards of participation have been drafted that have been recommended by the American College of Physicians for an "Advanced Medical Home."

Another goal of the Connect Care Choice Model of health care delivery is to provide self-management of chronic disease through a statewide interdepartmental and linked initiative to bring the "Stanford Self Management Model" to all chronically ill community residents throughout the state of Rhode Island. Self-management skills are especially necessary to help the chronically ill and disabled gain confidence in their ability to maintain independence, manage their chronic conditions, and assume personal responsibility.

Members who receive their medical care in the targeted practice sites will be screened for eligibility, and risk stratified by low, moderate or high risk based on acute hospital and ED utilization, chronic disease conditions, and co-occurring behavioral health conditions. Members whose practice site has sufficient volume of members, over 200, can move from low to moderate within the practice setting with the assigned Nurse Care Manger. Practices with smaller volume will have a Nurse Care Manager provided through a contracted agency. Because continuity of care is important to managing chronic illness, efforts will be made to keep the same NCM even when level of risk changes. Members' risk status will be determined, based on a risk profile algorithm.

Managed Care: Rhody Health Partners

Through Rhody Health Partners, DHS contracts with two of the top ten nationally ranked Medicaid health plans in America[3], to offer a comprehensive, integrated set of benefits to enrollees. Each member enrolled in Rhody Health Partners (RHP), receives an initial health screen, conducted by a member of an interdisciplinary care management team. The goal of the initial health screen is to assess the member's current utilization of services, and determine whether the member has needs that are not being met – medical, social, or behavioral. Upon completion of the initial health screen, the member is included in short-term, long-term or intensive care management, depending on their needs. Health plan care management staff work closely with members to ensure their input into the care plan, and encourage independent living and decision-making.

Care managers also coordinate with out-of-plan benefits including waiver services and services for clients with severe and persistent mental illness. Each health plan offers a large network of primary care, specialty care, and behavioral health providers. Health plan customer service staff will assist the members in finding a provider, accessing transportation or interpreter services, and help answer benefit-related questions. Health plans provide handbooks and newsletters to their members in order to educate them on topics like wellness, preventive care, and appropriate emergency room use.

Mandatory Enrollment of Children with Special Health Care Needs in Managed Care

Since SFY 2004 children with special health care needs have been enrolled in managed care on a voluntary basis. Currently, just over 4,700 children are enrolled. Approximately 5,200 children remain in fee-for-service. Just over half of these are children with commercial health insurance who have not been eligible for enrollment in managed care so as to not duplicate the private coverage. Remaining are approximately 2,400 children with special health care needs (CSHCNs) (without employer sponsored coverage/TPL) who remain in fee for services in this voluntary program. The program has been voluntary to this point given that CMS requires choice of health plan and only one health plan (Neighborhood Health Plan of Rhode Island) currently participates. The program could become mandatory (a) with a federal waiver permitting mandatory enrollment enrolled or (b) voluntary participation of a second health plan. One additional health plan has indicated a preliminary interest in discussing this possibility. Additionally, Connect Care Choice will be expanded to include pediatrics, thus giving these children a primary case management option as well.

Single Accountable Entity for Children's Behavioral Health

Under current arrangements, behavioral health benefits for children are fragmented; certain benefits are included within the RIte Care health plans and others remain within the fee-for-service system. Out of plan

[3] #2 and #9 in the nation respectively

services include CIS, residential services, home based therapeutic services (HBTS) and services of CEDARR Family Centers.

As part of the effort to ensure that every beneficiary receives the right services in the right setting, under this proposal the health plan will be responsible for the full continuum of behavioral health services for currently enrolled children, including community-based hospital step-down and diversionary services, enhanced coordination of care and assurance that services provided are medically necessary and in the appropriate setting. The proposal builds on successes over the past two years within managed care for children with special needs and children in substitute care arrangements in which there has been a 25% reduction in inpatient behavioral health days through development of enhanced continuum of community-based options. The population targeted to benefit from this initiative includes children with special health needs and children in substitute care arrangements.

Healthy Choice Accounts

As part of the Medicaid Reform Initiative, the State is committed to promoting greater personal responsibility for health care. Assuring beneficiaries have the opportunity to better manage their own health care is thus crucial. Health Opportunity Accounts (HOA) are among the vehicles now open to Medicaid beneficiaries that not only enable them to exercise greater control over their care, but also provide incentives and rewards for healthy behaviors.

The flexibility for the states to establish HOAs was created as part of the Federal Deficit Reduction Act of 2006. South Carolina and Indiana have both adopted variations of the HOA in their Medicaid programs with significant success. Rhode Island is among a number of other states proposing to use the HOA model to increase beneficiary participation in decisions about their own care.

The State's version of the HOA, to be called the Healthy Choice Account or HCA, uses the concept to encourage healthy choices and increase the information available to beneficiaries about their health care expenses. Specifically, all Rhode Island Medicaid beneficiaries will receive a periodic report that itemizes both the types of services they received and their costs. This information will make Rhode Island Medicaid beneficiaries more aware of their health utilization trends and, in doing so; serve as a source of education and encouragement for healthy lifestyle choices. Specific populations will be given the opportunity to earn rewards and as additional funding becomes available other populations will be given the opportunity to earn awards as well.

For example, each family member with a HCA will be eligible to receive up to 100 points per year by engaging in targeted healthy behaviors. The proposed target behaviors include:

- No Emergency Department (ED) use for ambulatory care sensitive conditions that could have been treated in a primary care doctor's office (+25 points each 6 month period)
- Completion of an annual Health Risk Assessment (+25 points annually)
- Annual physical exam by a primary care doctor (+25 points annually)
- Each use of the ED for ambulatory care sensitive conditions that could have been treated in a primary care doctor's office (-25 points each episode)

Each family member who earns 100 points per year will receive a reward such as a $10 grocery store gift card or pharmacy gift card. The use of HCAs is consistent with the guiding principles of Medicaid reform set forth earlier and an important element of the demonstration over the life of the waiver. The State is confident that

HCAs will assist in reducing the over-reliance on high cost venues like the ED and provide beneficiaries with a new avenue to exercise greater control over the cost-effectiveness of their health care.

Dually Eligible Beneficiaries

The dual eligible population includes many of the most frail and impoverished beneficiaries in the State's Medicaid program; not surprisingly, dual eligible beneficiaries tend to be the highest cost cases in both the Medicare and the Medicaid programs For seniors and people with disabilities who receive full Medicaid coverage, Medicare is the primary insurer and payor for most hospitalization and medical services. Medicaid as the supplemental insurer generally pays for some or all of Medicare's cost-sharing and for services such as non-skilled long term care, nursing homes, transportation, durable medical equipment, personal care services and - until January 1, 2006 - prescription drug coverage.

Several characteristics distinguish dually eligible beneficiaries from other Medicare beneficiaries: they are more likely to be female and living alone, reside in a nursing home or other long-term care facility, and suffer from chronic and serious health conditions such as diabetes, pulmonary disease and stroke. In addition, over 40 percent have a cognitive or mental impairment compared to nine percent of non-dual Medicare beneficiaries.

Between 2002-2005, very high cost case Medicaid beneficiaries in Rhode Island (over $100,000 of annual Medicaid spending) constituted 3% of the population but30% of Medicaid costs. Sixty-six percent (66%) of these high cost beneficiaries were dually eligible. Nursing home residents and long stay chronic disease in-patients constituted 15% of the population, but 35% of Medicaid costs. Among these beneficiaries, 91% were dually eligible with just over half (55%) presenting with an Alzheimer's/Dementia diagnosis. By contrast, beneficiaries living in the community were 82% of the population, but only 35% of Medicaid costs and 50% were dually eligible, 39% of which had a CMI diagnosis, 30% a depression diagnosis and 27% a diabetes diagnosis. (Data source: RI longitudinal linked database 1995-2005)

Given the needs of the dual eligible population and the costs of meeting them, Rhode Island is very interested in developing a partnership with the federal government that will facilitate better care management and coordination of services. The State would like to enter into a dialogue with CMS about the possibility of a including as part of the proposed global waiver demonstration project a unique component that will enable the Rhode Island Medicaid Program to assist the Medicare Program in the development of a person-centered integrated model of care for dually eligible beneficiaries. Central features of this component are as follows:

- The voluntary enrollment of Rhode Island dually eligible beneficiaries in the Connect Care CHOICE program with Medicare financial participation. This will provide dually eligible Rhode Islanders with another option for a coordinated care system across the spectrum of 'acute, sub-acute, chronic, and long-term care' settings that offers the right services, at the right time in the right setting;
- An assessment and service plan tailored to each beneficiary's unique level of care and service needs by the Assessment and Coordination Unit;
- The re-investing of Medicare savings into the development and expansion of home health care services;
- Enable the Medicaid program to gain access to Medicare claims and encounter data; and
- Authorization for the Medicaid single state agency to operate as a Part D plan, so dually eligible beneficiaries can voluntarily enroll.

Rhode Island is aware that the negotiation of this component of the demonstration proposal will require far lengthier analysis and further review, and will include parties other than the Center for Medicaid and State Operations. The dual eligible component of the proposed waiver is outlined here to illustrate the State's

commitment to include every facet of the Medicaid program in this proposed global waiver demonstration, if not immediately then in the long-term. Rhode Island will initiate discussion with federal officials about this aspect of Medicaid reform after the proposed demonstration is approved. The State's goal is to obtain federal authorization to include the dual eligible component as an amendment to the global Consumer Choice Compact waiver.

Premium Accountability and Personal Responsibility

Another mechanism for increasing personal responsibility and care management is to require beneficiaries to share in the cost of coverage. As the costs of that coverage rise, so too should the contributions of beneficiaries within certain income limits. Moreover, as Medicaid coverage was not intended to be a substitute for commercial insurance, it is important that beneficiary cost sharing reflect – albeit at lower levels – other forms of health coverage. Benefits available to most Medicaid enrollees – particularly on the children and family side – are more comprehensive than most plans in the commercial market. For the segments of this population that churn in and out of Medicaid as their employment status changes – primarily parents – tailoring benefits to be comparable to predominant forms of employer-sponsored insurance prevents substitution and promotes responsible utilization of ancillary services.

Outlined below are proposals that would implement co-payments for certain services and increase premium responsibility for beneficiaries and enhance efforts to ensure that all participants in the Medicaid program pay their fair share of the costs of Medicaid coverage.

1. Raise RIte Care Premium Rates to a Full 5% of Income

Current waiver authority with CMS and RI General Law allows the State to raise monthly premiums charged to RIte Care families at or above 150% to a maximum of 5% of income. At present, premiums are set at 3-4% of monthly income ($61, $77 and $92 depending on income level). Rates were last raised in August 2002. As indicated below, new rates would be $85, $106 and $114 for the three tiers.

% of FPL	# of families	Assume 5% reduction of families	% at premium level	Old premium rate	New premium rate
150-185	3,555	3,377	63%	$ 61	$ 85
185-200	703	668	12%	$ 77	$106
200-250	1,403	1,333	25%	$ 92	$114
Total	**5,661**	**5,378**	**100%**		

2. New RIte Care Premium Rates at 3% of Income for Families 133-150% FPL

Current waiver authority with CMS would allow the State to implement cost sharing for families between 133% and 150% of the Federal Poverty Level (FPL) at 3% of income ($45 per month).

FPL	# of Families	New Premium
133-150% FPL	2188	$ 45

3. Co-pays for RIte Care Populations

Currently in the RIte Care waiver, we have the authority to charge families at or above 133% FPL premiums up to 5% of income as well as certain co-pays. In the waiver proposal, we would also seek additional authority to charge co-pays for families below 133% FPL.

This proposal would require RIte Care beneficiaries to pay the following co-pays:

- Emergency Department Visits for Ambulatory Care Sensitive Conditions that could be treated in a doctor's office; and waived if admitted.
    - $3 per ED visit for all children and parents 0-150% FPL
    - $25 per ED visit for all children and parents above 150% FPL
- Prescription Co-pays
    - $0 for generic drugs regardless of FPL
    - $3 for brand name drugs regardless of FPL

4. RIte Care Premium Accountability

There are currently more than 5500 families, representing approximately 13,900 individual members, who pay a monthly premium to DHS as a condition of their participation in Medical Assistance (RIte Care/RIte Share). If a family does not pay premium for two months, they are sanctioned by the State and are disenrolled from Medicaid. This disenrollment is effective for four months. Approximately 140 families (300 individuals) are sanctioned each month. After the four-month sanction is fulfilled, a family/member can re-apply for the Medicaid program and if eligible, can re-enroll without ever having paid their outstanding premium balance.

This initiative would eliminate the four-month sanction period and instead, allow families who pay their balance in full to re-enroll. Those families that do not pay their balance will not be allowed to re-enroll until such time as the premium balance is paid in full. Under the new policy, we estimate that nearly 60% of families will pay up and get back on within two months of the sanction.

5. Streamlined Benefit RIte Care Benefit Package for Parents at or above 100% FPL

Eliminate certain health benefits including Dental, over the counter (OTC) drugs, and podiatry benefits for parents above 100% FPL currently enrolled in RIte Care.

This effort is to more closely align benefits for parents above 100% FPL with commercial health insurance benefits.

6. Self Directed Options for Katie Beckett Children

Children eligible for Medicaid through the Katie Beckett option qualify because they meet the required disability criteria established by the Social Security Administration and would require an "institutional" level of care if it were not for the services provided at home. Only the child's resources and income are considered when determining eligibility for Katie Beckett; the income of the parents is deemed unavailable, as it would be if the child resided in an institution. At present, parents are not required to pay a share of the costs for the for the Medicaid funded health coverage they receive.

Currently there are 1,632 children enrolled in the Katie Beckett program. Approximately 85-90% of these children have commercial coverage as their primary payer. Medicaid is typically used to cover their health plans' co-pays

and deductibles as well as services not provided through commercial insurance. The State will establish various self-directed care options that will afford parents greater choice and provide them the flexibility of arranging and purchasing the services that their children need in a more cost-effective manner. Additional information about the self-directed care options under consideration is contained in Appendix III.

7. Fair Share Employer-Sponsored Insurance

This change will require all Rhode Island participating Medicaid providers and vendors to furnish to DHS, upon request, information regarding their firm's employer sponsored insurance (ESI). By doing so, this will allow DHS to enroll applicants and beneficiaries into RIte Share whenever possible; thereby ensuring that Medicaid is payor of last resort. Currently, we request this information from our members upon application and recertification, but we have no authority to require this information from the employers.

8. Maintain Employer-Sponsored Insurance for Medicaid Eligible Mothers - NICU Cost Avoidance

Enroll MA eligible mothers of NICU babies into RIte Share, which will include coverage of the COBRA premium when necessary

9. Expand RIte Share to Maintain Medicaid Eligible Clients in Employer Sponsored Insurance (ESI)

This initiative would enhance and expand the third party liability (TPL) information DHS currently receives via the commercial insurance tape match to ensure the receipt of more timely and accurate data. More timely and accurate data will enable DHS to transition more families from RIte Care to RIte Share. This initiative would save public funds by maximizing the use of the employer's contribution to health insurance.

III. Smart Purchasing

Smart purchasing involves contracting upfront with a vendor, provider or other entity that accepts payment for an agreed upon price for a specified service or range of services for Medicaid beneficiaries. As the purchaser, the State sets standards related to quality and outcomes that the contracting entity is obligated to follow and for which it is ultimately held accountable. The State thus will have greater capacity to target services for all beneficiaries, a population or even a single coverage group when using this strategy. Moreover, the State can use "selective contracting" with one or multiple entities to stimulate competition and guarantee the best price.

At present, the way services are purchased in much of the Medicaid program does not promote competition among hospitals and other providers. As a result, the State is paying a wide range of rates for basically the same services and level of care. Smart purchasing will not only allow for one consistent rate, but it will also be tied to quality performance measures that ensure the State achieves the best health outcomes for every Medicaid dollar it spends. Additionally, smart purchasing is essential to achieve the broader reform and demonstration goal of making Medicaid "person" rather than "provider" centered, and to the extent feasible, market driven.

The State proposes to use the principles of smart purchasing to institute selective contracting for psychiatric inpatient beds and out patient non-urgent services. Other areas of selective contracting will be initiated if it is determined to be appropriate, cost effective and can maintain quality. Private sector healthcare purchasing significantly relies on selective contracting with a limited group of vendors in order to obtain the best prices and

achieve defined outcomes. The State proposes to seek competitive proposals for certain inpatient hospital services and will define vendor requirements to assure adequate access, quality and prices that are competitive in the healthcare marketplace. The State will make information about service utilization, actual expenditures and specified outcomes achieved available to the public, so that all interested parties, including health care providers, beneficiaries, and legislators will be able to evaluate the benefits of this purchasing strategy.

Selective purchasing will promote competition, value and performance. At the same time, selective purchasing will continue to allow for consumer choice and personal responsibility since any hospital licensed to provide in-patient psychiatric services or entity that can provide out patient surgical services will be eligible to participate in the purchased network at the best rate.

Selective Contracting – Inpatient and Outpatient Hospital

Currently, the State uses state-only dollars to purchase psychiatric in-patient care for uninsured individuals. This is an expensive system, which creates a fragmented network for insured and uninsured individuals. The selective purchasing of Medicaid psychiatric in-patient beds intends to fold the uninsured into this purchase. This will allow for a substantial saving and, more importantly, provide one comprehensive system of care with unified outcomes rather than a two or three-tiered system. This divided system exist because we purchase Medicaid beds and uninsured beds through two different systems and two departments and the third level is based upon private insurance. A portion of the savings will be reinvested in community-based care since the acuity level for many of these individuals allows for a mid-level care placement.

Rhode Island is exploring modifying its current hospital reimbursement system and is looking at implementing a DRG system of reimbursement. A Hospital Task Force has been established to explore this reimbursement methodology. During this process a small number of diagnoses have been identified as 'outliers, Mental Health has been a challenge for DRG developers. These diagnoses are not easily identifiable in claims data and as a result a number of states carve out or makes "outlier" payments for mental health and substance abuse treatment. For FY 2006 Rhode Island Medicaid inpatient claims, the top 5 diagnoses categories by payments were for mental health. These payments across community hospitals exhibited a large variation in average cost per stay. The variances are not surprising given the current negotiated reimbursement system. The State specifically will issue requests for proposal for the inpatient hospital services that are not recommended as an appropriate component of the Hospital Task Force DRG system

Hospital outpatient reimbursements exhibit the same variations for selected ambulatory surgeries. For example, tonsillectomies range from $720 to $800. These procedures will be added to the selective purchasing of inpatient service outliers. The State expects to realize a 20 percent reduction to the combined baseline expenditure of $45 million for these selected hospital services.

Smart Purchasing of Pharmacy Services

Rhode Island proposes to implement a number of initiatives that will help contain the growth of pharmacy expenditures. These actions include:

- Expanding the class of drugs on the Preferred Drug List;
- Auditing pharmacies to ensure compliance with the 'favor nation' policy;
- Increase rebate collections;

- Using mail order to pay for certain category of drugs; and
- Providing incentives to individuals who switch from brand to generic drugs

Psychiatric Preferred Drug List

For SFY 2007, $12 million was spent on anti-psychotic medications. This represented 18% of the total drug expenditure. Currently, this drug class is exempt from inclusion on the Preferred Drug List (PDL). The PDL was implemented in January 2007. In the first three quarters of 2007 the State has collected a total of $1.3 million in supplemental rebates. Doctors prescribing less expensive but clinically effective medication achieved additional savings. The inclusion of the antipsychotic medications on the PDL can further contribute to a savings in the Medical Assistance Program. This transition can be accomplished without any disruption is medical care for our beneficiaries.

Hospital Pharmacy Rebates

The Federal Deficit Reduction Act of 2005 requires that for FFP to be available, the State must collect rebates on all covered outpatient drugs. This includes medical offices and hospital outpatient settings. To do this, any claim submitted for a covered out patient drug must include the procedure code along with the corresponding National Drug Code (NDC). Only drugs dispensed from a manufacturer that has a signed rebate agreement with the Federal Rebate Program are reimbursable.

The RI Medicaid began processing claims from outpatient settings, excluding hospitals, on January 1, 2008 that included NDC numbers along with procedure codes. Due to problems and high cost in implementation of this program by the required date, the State asked for a waiver from CMS for an extension of the implementation for the hospitals. The waiver was granted until June 30, 2008. At that time any claim submitted from any out patient setting for a covered out patient drug must contain both the procedure code and the corresponding NDC representing the actual drug dispensed. Any claim submitted after that date without the proper information will be denied.

Reduction in Administrative /Contingency Payments

DHS contracts with three Health Plans (Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United Healthcare of New England), which participate in RIte Care, Rhode Island's mandatory capitated Medicaid managed care demonstration program for the State's family related Medicaid coverage groups. Additionally, DHS contracts with Neighborhood Health Plan of Rhode Island for enrollment of children with special health care needs and children in substitute care arrangements. DHS proposes to reduce its monthly administrative payment to each RIte Care participating Health Plan by $5.00 per member, per month as of March 1, 2008.

The Consumer Choice Medicaid Global Waiver Request

Rhode Island proposes to replace its current Medicaid Program with a new state-federal global compact that provides flexibility in exchange for federal budgetary certainty. Over the next five years Rhode Island will operate its entire Medicaid program under this demonstration. All persons currently eligible for the Rhode Island Medicaid program will be under the provisions of this waiver. During the this period Rhode Island will create options and programs that will divert and transition individuals from high end care venues to less costly but appropriate settings, provide beneficiaries with the necessary information to make informed choices,

mandate that all beneficiaries have a medical home, promote personal responsibility and encourage competition and quality.

The global waiver demonstration proposed includes the tools necessary to address the needs of beneficiaries in a holistic and person-centered manner, while providing the State with the flexibility to respond to change. The waiver will allow Rhode Island to use federal Medicaid funds to finance a broad array of community support services, administrative supports and provide incentives to beneficiaries who practice "healthy life behaviors".

Briefly, Rhode Island proposes with the approval of federal authorities to:

- Enter into a five (5) year agreement with CMS under a section 1115a waiver.
- Accept an aggregate Federal annual allotment for the State's Medicaid program, to be trended forwarded at an agreed upon rate. The trend rate will cover medical inflation and projected caseload growth with protections in the event of a national emergency or a significant economic downturn.
- Control the growth in annual expenditures for the Rhode Island the Medicaid Program.

Accordingly, is Rhode Island will be seeking approval of the following requests:

- Authorization to waive Title XIX provisions requiring state-wideness to allow for the provision of different services in different areas/regions of the State;
- Permit the State to provide non-Medicaid State Plan services to the demonstrations population with full Federal participation;
- Authorization to waive the Title XIX comparability requirements to allow for the provision of different services to members of the same or different coverage groups;
- Waiver of the Title XIX requirements prohibiting states from restricting the amount, duration and scope of services included in the Plan;
- Enable the State to establish waiting lists for non-traditional optional Medicaid services;
- Flexibility to modify application of certain institutional income and resources rules;
- Authorization to include only the income and resources of an applicant when determining financial eligibility for individuals in certain specific coverage groups;
- Flexibility allowing the State to collect spend down as a monthly premium for beneficiaries receiving HCBS when applicable;
- Authorization to waive Title XIX requirements prohibiting states from restricting freedom of choice and thus selective contracting
- Discretion to waive Medicaid requirements to retroactively pay for medical assistance;
- Authorization to expand cost sharing requirements above the 5% of income threshold for beneficiaries in certain populations;
- Flexibility to establish a three-tiered level of care paradigm to use as the basis for determining service care and setting needs;
- Enable the State to implement Health Savings or Power Accounts that provide incentives/payments to beneficiaries who reach certain prevention and wellness targets;
- Permit the State to cover children in DCYF custody who are remanded to the RI Training School but reside in the community as well as children in need of Medicaid services in the community who would otherwise only be eligible if living in substitute care, including high cost residential venues;
- Authorization to provide health coverage and services to individuals over the age of 65 that are limited in scope and available only in the home and community- based setting;
- Discretion to treat Skilled Nursing Services as a community-based Medicaid rather than as long-term care;

- ❖ Flexibility to institute a living expense disregard for those beneficiaries who require a high level of care but reside in the community; and
- ❖ Authorization to seek other waivers, discretion and flexibility the State and CMS deem necessary and appropriate to operate the demonstration project.

The State may request CMS to consider expenditures not otherwise included in Section 1903 of the Social Security Act in this demonstration such as:

- ❖ HCBS for individuals who are not eligible for Medicaid and not at immediate risk of institutionalization;
- ❖ Compensation service for caregiver spouses;
- ❖ Services provided during presumptive eligibility period;
- ❖ A coordinator of chores services provided by faith based organizations;
- ❖ Funding the increase administrative costs of the Assessment and Coordination Unit;
- ❖ Any that may be potentially disallowed based on OIG audits or Medicaid Eligibility Quality Control findings;
- ❖ Transition services; and
- ❖ Research & Evaluation as well as External Quality Reviews

The State may request other waivers, which are necessary to facilitate managing care, de-institutionalization, providing home and community-base services, and purchasing services and care that favorably affects the State and the population it serves.

The Consumer Choice Medicaid Reform Waiver will be a collaborative, cross-departmental effort involving all the agencies within the Executive Office of Health and Human Services as well as other segments of state government, the private sector and stakeholders. The responsibility for the administration of the waiver will be the Department of Human Services and EOHHS. The Department of Human Services will be responsible for the day-to-day management and for meeting all reporting requirements.

Rhode Island is exploring the option of establishing its single state agency as a health plan organization. Under such an arrangement, CMS would make payments to the State. The State Medicaid Agency would then take on the responsibility of entering into agreements with other State agencies, health plans, individual providers or networks. This payment could be either an aggregated annual allotment in which the State assumes full risk or, if CMS were interested, Rhode Island would consider entering into a gain sharing arrangement with the State.

Under either scenario, the allotment will flow through the Single State Agency, which then will distribute either under an interagency agreement, contracts or provider agreements funds to each department within EOHHS that has legal and budgetary responsibility for the administration of programs serving specific populations.

Rhode Island believes that that the federal-state compact proposed in the Global Consumer Choice Compact waiver demonstration described herein benefits both levels of government and all Rhode Islanders The Stated is convinced that the proposed waiver will satisfy the federal government and meet the needs of its beneficiaries, stakeholders, and the networks of community and institutionally based providers that serve them. Moreover, the demonstration builds upon the work of a number of stakeholder efforts that have built the foundation for the State's Medicaid reform effort.

In sum, the proposed Global Consumer Choice Compact waiver will give the Rhode Island the flexibility to restructure its benefit package to address the needs of its beneficiaries, and allow it the ability to make the programmatic changes that will ensure that the right services are delivered at the right time in the right setting.

Appendix I
Rebalancing the LTC System: Related Initiatives and Grants

Summary of Medicaid-related Long-Term Care Initiatives

- **Real Choices Systems Transformation Grant:** A five-year grant awarded to the state in 2006 targeting elders and adults with disabilities on Medicaid who receive long-term care supports. The goal of the grant is to implement the state's strategic plan for long-term care reform designed to improve access to LTC supports, develop and institute a comprehensive quality management system,

and establish and maintain an effective financing system for LTC supports. The RCST grant supports and furthers the goals of the State's two other RCST grants focusing on ensuring Medicaid beneficiaries receive the care they need in the most appropriate and least restrictive setting.

- **The 2006 Long Term Care Reform Act:** Known as Perry-Sullivan Reform, the Act established a mandate and framework for making several major changes in the state's long-term care system which directly affect Medicaid. The most significant of these changes relate to transitional efforts and the reinvestment of any Medicaid savings derived from reduced nursing facility days directly to home and community-based services. Based on estimates of first year savings, the state has submitted requests to CMS for three 1915(c) waiver amendments (Aged and Disabled, Habilitation, and PersonalChoice) to add Community Transitional Services, and additional waiver slots in community based settings where current capacity has been reached.

- **Consumer-Directed Care:** Rhode Island received Robert Wood Johnson Foundation Cash and Counseling grant in 2004, to develop and implement a new statewide cross-population consumer-directed program. Since 1986 Rhode Island has had a 1915(c) fee-for-service consumer directed waiver targeted to those with hemi- or quadriplegia and operated by an Independent Living Center. During 2006, the original waiver was phased out while a new Independence Plus 1915(c) waiver (entitled PersonalChoice) that features budget and employer authority was phased in. The PersonalChoice waiver is expected to eventually include approximately 450 people (more than 10% of the state's nursing facility level of care waiver population), and is available without any waiting lists to anyone meeting the appropriate level of care.

- **PACE:** The Program for All-Inclusive Care for the Elderly or PACE program coordinates and provides comprehensive, primary, specialty, and preventative medical care, as well as community support and social services enabling older individuals to continue residing in the community. The Department of Human Services in collaboration with the Department of Elderly Affairs and the University of Rhode Island worked together with CareLink, a not-for-profit management service organization, to establish a PACE Program in Rhode Island. The PACE Program began enrolling beneficiaries on December 1, 2005.

- **Medicaid Transformation Grant** – RI Medicaid Health Information Exchange and RIte Resources: A two year grant from CMS that provides funding to expand State's Health Information Exchange to include Medicaid related data sources and types – e.g., CHOICES module – and develop materials to educate Medicaid beneficiaries about enrolling in the HIE. Additionally, the grant provides funding for development of "RIte Resources", a web-based interactive data exchange that provides real-time information about care setting and service options to consumers, providers and discharge planners.

Summary of Medicaid-related Long-Term Care Initiatives

- **CHOICES MMIS Module** – The CHOICES MMIS Module is a Medicaid Management Information System initiative to design and implement a data warehouse and decision support system that will link encounters, claims and assessments. The State will use the module as the foundation around which to develop systems supports for managing its programs and various populations. The CHOICES MMIS Module will include the ability to do predictive modeling and data analysis. It also will include web-based applications that will streamline the level of care determination process and provide information to providers and beneficiaries.

Appendix II
Options and Opportunities for Self-Directed Care

Under the proposed demonstration, Rhode Island will endeavor to further its committed to providing home and community-based personal assistance services through a self-directed delivery system. Currently, there are several programs that offer some form of self-direction. Under this Waiver initiative, Rhode Island seeks to develop an inter-agency policy framework and consistent approach to the availability of self-directed supports. The design of this consistent approach will be based on the experience and lessons learned primarily from the existing *RI PersonalChoice*, Rhode Island's 1915(c) Cash and Counseling Waiver, the 1915(c) Developmental Disabilities Waiver, and the Personal Assistance Service and Supports (PASS) Program.

Cash and Counseling Waiver

RI PersonalChoice has operated since 2006. Participants in this Waiver are adults with disabilities and the elderly who want and are capable of directing their own services or who have a designated representative able to perform this function. The Waiver currently serves approximately 150 individuals. The services that can be accessed through the Waiver are personal care assistance (aid in daily living tasks such as bathing, dressing, toileting, meal preparation, and other tasks), home modifications, personal emergency response systems, minor assistive devices, and home-delivered meals.

A common assessment tool is used by trained staff at community-based Advisement Agencies to determine each individual's needs. This assessment is used to determine a monthly service need, which is then translated into a monthly budget amount. Each participant (with assistance from a Service Advisor) develops an individualized budget/service plan detailing how he/she will purchase personal care services and/or other goods and services to address individual needs. Participants have a great deal of freedom in determining staffing level, hours of service, scheduling of service, wages to be paid to care givers, and vendors for goods and services. A separate Fiscal Intermediary agency handles all financial and personnel tasks for the participant. These tasks include processing timesheets and paying caregivers, making all required federal and state employment related payments on behalf of the participant (who is the employer of record), arranging for Worker's Compensation coverage and conducting Criminal Background checks on all caregivers. Fiscal Intermediary agents also process and pay invoices to vendors for goods and services purchased by the participant (as long as the services are part of the approved budget). Participants also have an option of saving money in their monthly budget for the purchase of more expensive items, as long as the items are related to the individual's disability and will improve their independence (i.e. Service Dog, microwave oven, etc.).

1915(c) Developmental Disabilities Waiver

People with developmental disabilities who participate in the 1915(c) Developmental Disabilities Waiver can also choose to access services through a self-directed option. People are able to manage all or some of their funding by using a fiscal intermediary as a conduit for Medicaid dollars. Ocean State Community Resources has been certified for approximately fifteen years to act as a fiscal intermediary and administer OPTIONS, an alternative to the traditional service delivery system. Created in the spirit of the Self-Determination movement, OPTIONS allows people to take control of all the support resources already at their disposal. From funds allocation to staffing, contracting to scheduling, and bookkeeping to supervision, OPTIONS gives people the real power to make the decisions that affect their ability to live truly independently.

The OPTIONS program allows the person to be considered a legal *employer* in the State of Rhode Island. Developed in coordination with the Internal Revenue Service (IRS), people enrolled Options are "sole

proprietors" via the IRS Form SS-4. Once the new employer has his/her own employee identification number (EIN) his/she will be classified by the IRS as a Household Employer. Being a household employer allows the person or his/her representative to hire individuals of their choice. OPTIONS staff assists the new employer in every step of the way from obtaining his/her EIN number, screening new employees, managing financial resources, to paying the employer's share of the quarterly IRS taxes.

The OPTIONS program provides an opportunity for a person with a developmental disability and his/her family the flexibility to choose whom they want to provide the services they need, how much to pay, when they need the support, and what the employee(s) will do for them. Due to the minimal fee structure provided by OPTIONS, the state approved dollars stretch much further than a traditional service delivery provider resulting in people receiving more service hours per week. In addition, people hired are typically paid higher wages than staff from community agencies. Currently there are approximately 200 people with developmental disabilities statewide who are involved with the OPTIONS program.

Personal Assistance Service and Supports (PASS) Program

PASS is available to Medicaid eligible children with chronic and moderate to severe cognitive, physical, developmental and/or psychiatric conditions. Under this program, the worker is employed by a certified PASS Agency that is responsible for the background checks, payroll, and basic training and orientation. It is the family of the child, however, that is responsible for the recruitment, specific training, management, and supervision of the PASS worker. The PASS program requires the active participation of the child and family in determining service needs and how those needs are to be met but also provides the family with support in the training and supervision of PASS workers.

Self-Directed Option in the 1115 Waiver

The knowledge and best practices the State has learned from both the RI PersonalChoice Waiver, the 1915(c) Developmental Disabilities Waiver, and the PASS Program will be used as the basis for a statewide coordinated approach to expand the self-directed option to more Medicaid eligible elderly individuals and individuals with disabilities who are assessed and found to need personal assistance services. This approach will mirror the provisions outlined in the CMS 9/13/2007 State Medicaid Director Letter and the January 18, 2008 Proposed Rule on Self-Directed Personal Assistance Services Program State Plan Option (Cash and Counseling). Even though the intent of the State is to initially establish the program under the same provisions that will exist in the State Plan, as the State is pursuing is a global, comprehensive Demonstration Waiver, the State seeks to implement this service delivery option under the 1115 Waiver authority. It is the State's expectation that in two years the State will expand the self-directed option to different populations and for different services.

Self-Direction Alternative for Other Populations

The State is currently exploring the feasibility of providing a self-directed option to three new populations: children eligible under the "Katie Beckett" provision; individuals with behavioral health needs; and children at risk for extended residential placement.

Children eligible under the "Katie Beckett" provision

Parents of children eligible under the "Katie Beckett" provision have advocated for a number of years for more flexible services and more consumer direction. A consumer-directed vehicle would allow parents to use the monies the State would otherwise have spent on Medicaid claims in ways that are more individualized to the needs of their child: recruiting and employing their own support personnel and bypassing agency mark-ups,

purchasing services and goods that would be difficult for Medicaid to pay for directly, etc. While the development of this option needs to be carefully pursued and may not work for all families, the State believes that many families, with appropriate counseling, can both navigate such a system and find greater value than the current service options. As is the case with the RI PersonalChoice Waiver and the 1915(c) Developmental Disabilities Waiver, significant consumer protections need to be built into this alternative. The State will work closely with families in the development of this service delivery option.

Individuals with Behavioral Health Needs

Rhode Island has recently been awarded an Access to Recovery (ATR) grant for substance abusers by SAMHSA. This grant does not apply to individuals eligible for Medicaid, but the State can use the lessons learned from this grant to begin the development of a self-directed care option for Medicaid-eligible individuals who need substance abuse treatment services or other behavioral health services.

The ATR grant utilizes a web-based, paperless voucher system to reimburse providers for clinical treatment and recovery support services provided through a consumer-directed process of service selection. Individuals being released from the Adult Correctional Institution or the RI Training School, as well as adults identified by the Department of Children, Youth, and Families (DCYF) Protective Services as substance abusers, are eligible for the program. Clients are first screened and then, if determined eligible, provided with a menu of services and service providers from whom to choose. The client is also asked to choose a 'Recovery Coach' who will help through the recovery process. State staff 'loads' the electronic voucher with an initial amount based on the client's level of need and service selection, and makes an initial appointment with the provider of the client's choice. The client presents at the provider within 30 days and is given a comprehensive assessment, after which a more comprehensive service plan is developed and amendments to the initial voucher amount/configuration are made if necessary. Providers enter documentation of service into the system via the Internet and are automatically reimbursed by the Department of Mental Health, Retardation, and Hospitals (MHRH) on a monthly basis without the need for generating invoices.

At-risk Children and Youth

The other population for whom the State is pursuing a self-directed option is the children and families who receive services and supports from DCYF. DCYF plans to introduce WRAP RI, an integrated system of care and wraparound planning, into DCYF's residential and out-of-home, community-based services for children, youth and their families, many of whom are at high-risk for extended residential placement. WRAP-RI will be the planning mechanism for all families and will be based on coordinated, flexible, individualized, family centered, community based and culturally competent services based on the needs of the family. WRAP-RI is a model of service planning and delivery where services and supports are "wrapped" around each child and family according to their unique needs. These services are flexibly adjusted, as the family's needs change. The Wraparound Process, which puts "*Family Voice and Choice*" front and center in setting children's goals in identifying the services and supports that the child and family need to reach them, results in highly individualized plans that make the best use of needed resources. High-Fidelity Wraparound[4] service planning and delivery has three critical functions, which are being built into this model:

- Ensuring fidelity to the wraparound process through: training; credentialing; coaching/supervision; and independent monitoring of the fidelity of the wrap process.

- Using child and family outcomes as the key indicator of the effectiveness of the wrap plan and services

[4] For more information on High Fidelity Wraparound, please see the National Wraparound Initiative website, www.rtc.pdx.edu/nwi/.

at both the family and system level. Outcomes measures must include: safety; permanency; stability; MH symptoms; school functioning; and criminal justice contacts/involvement.

- Measuring and monitoring utilization in real-time. This requires: real-time utilization data provided to Wrap Coach/Supervisors who are held responsible for ensuring appropriate utilization of resources; Wrap Coaches who identify wrap plans needing adjustment and offer options to wrap teams; Wrap Teams that make final decisions about how to adjust resource use; and utilization and outcomes data that are analyzed at multiple levels, including: by family demographics, by family need and functioning; by Supervisor, by Family Service Coordinator, and by program, with results fed back to programs and supervisors on a regular basis.

As WRAP-RI is implemented, every opportunity for families and children to access services in a self-directed manner will be explored.

Appendix III
Development of Residential Service Options

I. Shared Living Arrangements

A Shared Living program provides a number of notable benefits when compared to group homes, skilled nursing homes or other residential facilities not only for elders and adults with disabilities, but for children with special and/or therapeutic needs as well. The chief advantages of the share living arrangement (SLA) model across populations relate to:

1. Cost Containment --Since private homes are utilized as the residential setting, there is no associated capital expense; programmatic costs are significantly lower than group home placements or nursing homes and there are minimal administrative costs. In short, the SLA program design makes maximum us of existing community resources to avoid duplication and contain costs.

2. Customized Services --The Individualized Service Plans (ISP), developed by the beneficiary and ACU are customized to meet the psychosocial and habilitation training needs of each individual and drive the provision of services.

3. Appropriate Care Setting -- Shared Living services are delivered in independently contracted family homes in neighborhoods that may have personal meaning and provide comfort for the beneficiary. Each beneficiary is matched closely with a host family residing in area that provides ready access to neighborhood amenities, community activities and public transportation.

4. Supported Personalized Care – The head of shared living household is the primary caregiver responsible for implementing the ISP. The primary caregiver is supported by the services of the multi-disciplinary team of habilitation professionals that developed the ISP in collaboration with the beneficiary, as well as by medical and behavioral specialists who are available to provide consultation on an as needed basis.

5. **Continuity and Change across the Lifecycle** – One of the great virtues of the SLA model is that has the capacity to adapt to the changing needs of beneficiaries – that is, it is not age/condition specific. Beneficiaries need not move to an alternative care setting or system when they age out of one coverage group and into another – e.g., reach age 21 or 65. Moreover, within certain parameters, the SLA model allows beneficiaries to remain in the same service setting when their level of care needs and ISP change if the host family is willing to receive the necessary training and authorizations.

In addition to these advantages, program participants may expect the following host home service components as part of their service package:

- 24 Hour Home-Based Support and Supervision;
- Family Support;
- Development and Monitoring of an Individualized Service Plan (ISP); and
- Community Participation Activities.
- Medication Management
- Respite

Although all beneficiaries residing in SLAs will have access to these services, the scope and intensity will vary in accordance with their level of care and service needs as determined by the ACU.

Additionally, the Shared Living facet of the State's Medicaid reform community services plan enhances services by assuring a focus on continuous quality improvement in program operations and procedures. Satisfaction surveys will be administered routinely. Beneficiaries, their families or guardians, and representatives from the referring agency will all be regularly involved in the evaluation process; and comprehensive assessments of program strengths and weaknesses will be conducted to ensure beneficiaries are receiving the high quality community-based services they need

The success of the SLA model depends in large part on the procedures for recruiting and retaining participating caregivers. The State has developed and begun implementation of a plan to attract caregivers that mirrors closely the successful approaches adopted by other states.

Caregivers will be recruited from diverse social and ethnic backgrounds, levels of education, interests, and communities of origin. They will originate from urban, suburban, and rural neighborhoods, and come to the program for consideration through a variety of recruitment mechanisms, which include, but are not limited to: advertisements, flyers and bulletins, presentations to community and faith-based groups and word of mouth/through other caregivers.

Candidates will be asked to complete an application packet that explores the prospective caregiver's attitudes, typical household day, and family history. The focus of this assessment is thus not only the family constellation and type of residence, but also motivations for enrolling in the SLA program. Candidates may be eliminated at this juncture for a variety of reasons, including: inadequate housing arrangements, lack of transportation, or the revelation of a criminal history.

Interested caregiver candidates then will have to undergo a training/orientation session(s) that provides them with the opportunity to learn both about the benefits and limitations of the program and the beneficiaries. A home visit is then conducted that focuses on environmental health and safety. In some instances, repairs and/or modifications to the home are needed before a candidate is approved to participate in the SLA. Prior to further consideration, each family member must pass a criminal record background check. The prospective caregiver's physician must give medical authorization to proceed further with the application process as well**.** The State is confident that the safeguards built into this review system will ensure that SLA caregivers are committed to providing beneficiaries with the right services in the right setting. The State's goal is to provide sufficient incentives to increase the number of approved SLA caregivers by 400 over the next five year(s).

The State expects the Shared Living model will be utilized for individuals with severe behavioral, physical, or developmental disabilities regardless of the complexity of their medical condition, the severity of their developmental disability, or the challenges of their behavior. The SLA model that has been developed is open to virtually all Medicaid beneficiaries including medically fragile children, children and adolescents with serious emotional disturbances and/or court involvement, individuals of all ages with mental retardation, those with acquired brain injury, and elders with age-related physical limitations to reach their fullest potential in home and community-based settings.

We expect to develop between 150 to 200 additional shared living arrangements over the 09 Fiscal year across all ages and disabilities. According to numerous advocacy organizations including the area agencies on aging, the Generations Project, and the AARP, Americans overwhelmingly (83% as surveyed by a 2005 AARP study) prefer 'aging in place', in a community or home-based setting. Shared living is a cost-efficient alternative to nursing homes, providing elders with access to high-quality long-term care with a focus on dignity and personal

independence. With 84% of Medicaid long-term care funds currently subsidizing placements in nursing homes, Rhode Island could greatly benefit from a less expensive alternative. The needs of persons leaving nursing homes or other similar care facilities do not differ significantly from those leaving some of the publicly-run DD group home group homes and who have moved into shared living arrangements over the past year

Appendix IV
Transition and Diversion Planning for by Population

Overview

Staff from the Assessment and Care Coordination Unit work in tandem with the provider transition teams and hospital discharge planners to meet all individuals from the facility who are seeking to transition to a community-based setting.

Medicaid beneficiaries and their families will have the opportunity to express their preferences for service delivery, including desired geography and prospective roommates. A series of informational meetings would be scheduled to gauge general interest in transition back into the community and to begin to make individual assessments and formulate transition plans for the beneficiaries. When indicated, a registered nurse will meet with consumers who have significant medical involvement. These on-site meetings will allow program staff to develop transitional medical service plans and anticipate home modifications and/or durable medical equipment needs which will accommodate the strengths and needs of the persons seeking community re-entry. Availability of ancillary health care services in the preferred community will be evaluated in relation to the needs of each individual.

When indicated, caregivers will work directly with the transitioning consumer at the nursing home for up to two weeks before actually moving. Caregivers will shadow nursing home staff at various times and at different activities with increasingly active involvement. Through this process, caregivers learn the routines and rhythms with which consumers are most comfortable as well as any circumstances that may precipitate health or other challenges. Once a setting of care is identified consumers will be given the opportunity for visits, including overnight visits, to ensure a seamless transition to the community.

Populations Served

Individuals will require assistance with activities of daily living, such as ambulating, eating, dressing, grooming, bathing, and incontinence care. They may have limited mobility, may use a wheelchair and may require assistance getting into and out of bed. Individuals will likely have one or more of the following health and personal care needs: eating limitations and special or restricted diets; limited medication administration and nursing; and transportation to/from doctor visits and other activities. Referred consumers may have challenges including but not limited to the following cognitive and/or physical illnesses: cardiovascular disease, hypertension, congestive heart failure, diabetes, Alzheimer's disease or dementia, hearing and/or visual impairments, deafness, blindness (may require adaptive equipment), depression, or anxiety disorders. .

The additional goals of the transition are:

- To maximize functional abilities and promote independence to the greatest degree possible.
- To minimize the individual’s social isolation through involvement in community activities.
- To ensure cost-effectiveness and decrease service duplication by working closely and cooperatively with all other agencies involved with the individual.
- To improve the quality of life for all residents by promoting consumer dignity and ensuring choice and decision-making for all participating individuals.
- To offer a range of supportive services that can be adjusted as the needs of the individual change over time.

Children in High cost Placements

As noted earlier, the current system for providing care to children with multiple medical and behavioral needs is over-reliant on high cost placements. The State is proposing to transform the existing system of care into a residential and community-based support system by implementing a high-fidelity wraparound process for identifying the child and family's needs at the outset of placement. By providing incentives to the residential and community providers to "wrap" services around the child and family, the child can be diverted from a high cost, restrictive placement or returned to a community setting on a more timely basis with additional supports for the family to support the child's transition. These community settings include the child's reunification with his/her biological parents, an adopted home, living with a legal guardian, a foster home, or transitional living arrangement.

Currently, the State reimburses residential providers for 355,000 bed days of service, more than one third of those bed days (125,000) are provided in high-end residential treatment, including 40,000 bed days in out of state residential treatment facilities. The average per diem of these programs is $400 per day; the total cost for these programs, $51 million, is half of the total cost for residential care in the current fiscal year.

As part of the Medicaid reform's effort to ensure every beneficiary receives the right services in the right setting, the State plans to contract with two-to-four service network partnerships statewide, which will be responsible for managing a full array of residential services, and for establishing an expanded network of community-based services, including evidence-based practices, that can meet the needs of this group of children and families for behavioral health treatment, rehabilitation and support.

Each Service Network Partnership must ensure access to residential programs and a comprehensive array of community-based services, be capable of providing strength-based, culturally competent rehabilitative and supportive behavioral health services for children with SED and/or Developmental Disabilities and their families. These services will be purchased through fee-for-service or subcontracted agreements with current or newly developed provider organizations.

These Partnerships will be responsible for the implementation of a High-Fidelity Wraparound[5] model of service planning and delivery. High Fidelity Wraparound is a nationally recognized model of developing and delivering strength-based services, including evidence based practices, to children with severe emotional disturbances and their families. Currently, several states utilize 1115 waivers that have incorporated High Fidelity Wraparound into their model of cost containment for children's behavioral health services, including Arizona and Maryland.

DCYF is proposing to maintain an average daily census of 1,000 families but work with a Wraparound Contractor to reduce the census is residential to 700 and follow the additional 300 children in community settings listed above.

DCYF expects to provide 248,000 bed days at a cost of $67 million and provide community supports to 300 families at a cost of $17 million for a net savings of $16.3 million.

[5] For more information on High Fidelity Wraparound, please see the National Wraparound Initiative website, www.rtc.pdx.edu/nwi/.

Behavioral Health for Adults

Rhode Island will use the Medicaid Waiver initiative to continue to move the behavioral healthcare system towards the model outlined in the report of the President's "New Freedom Commission on Mental Health". The Commission's emphasis on mental health being essential to overall health; care being consumer/ family driven; elimination of disparities in service accessibility and provision; aggressive promotion of evidence-based practices; appropriate screening, assessment, and referral to services; and utilization of technology to access and disseminate information provide a close match to the principles outlined elsewhere in this Waiver. The process will flow naturally from the interagency collaboration stimulated by Waiver preparation and will result in an interagency collaborative structure at the State level for the planning and implementation of behavioral health promotion, prevention and treatment services. The resulting system will enable State agencies to utilize interagency agreements and braided/blended funding to promote recovery; improve the quality of life; and provide the right service at the right time for mental health recipients across the life span wherever they present for services. One of the primary results of this approach will be to avoid the escalation of cost and the burden of illness that is the result of an uncoordinated approach to care. System progress will be managed through the development of performance measures that will monitor both funding and service provision and outcomes.

In keeping with State's desire to comply with the principles set forth in the Olmstead decision, we plan to aggressively pursue the right of individuals with disabilities to live in the community rather than in institutions through the creation new levels of community-based care. Over the course of the Waiver, we envision that these strategies will include, but not necessarily be limited to, specialized community tertiary care residences; assertive community treatment teams with enhanced staffing aimed towards the care that elderly clients moving from nursing homes might require; shared living opportunities; enhanced assistant living facilities; and specialty residential developed to meet the needs of groups of clients with similar issues (e.g. elopement risks with significant personal care requirements). Access to the specialized tertiary care residences and specialized ACT teams will eventually come under the purview of the State assessment unit to ensure appropriate utilization and movement across the spectrum of care. Additional statewide emergency response and assessment capacity across the lifespan will be created for those who would otherwise utilize emergency rooms and general hospital acute care inpatient beds in cooperation with DHS. This initiative will be built around the current model used for handling state-funded psychiatric inpatient and detoxification clients, which relies heavily on the development of hospital alternatives and aggressive follow-up to prevent re-hospitalization.

Individuals with Developmental Disabilities

Many of the concepts involved in the Medicaid reform are in policy and practice in the Division of Developmental Disabilities/MHRH. For many years people with disabilities have been informed of funding available to them to purchase supports *(voucher concept)*. People have had the opportunity to choose the types of services/supports that best meet their needs and they can choose from any of the 38-certified/licensed providers or choose to manage their own funding and supports through a fiscal intermediary *(self-direction concept)*. The Division has historically administered a community system that is based on the components of the HCBS Quality Framework to assure the health and safety of individuals and a strong set of values that include opportunities for people to live quality lives and actively participate in their local communities, like any other citizen.

The Department of MHRH has been working collaboratively with various stakeholders groups (advocacy organizations, families, and provider agencies) in a leadership capacity to address critical systems issues consistent with national trends and best practices in the field of developmental disabilities to reform various

components of the system to develop a more sustainable system and to further develop creative options for service delivery. Issues being addressed include:

- Self-Determination/Life Choices Broker
- Housing
- Employment
- Expanding Residential Choices and Opportunities, and
- Pay for Performance

The Department is in the process of establishing a protocol to conduct a comprehensive clinical assessment of each individual in the developmental disabilities system to identify the service/support needs of each person, review high cost services, set individual budget allocations and restructure and standardize service reimbursement rates for providers.

The past investments by the State of RI in community services/supports for adults with developmental disabilities and their families position us to make the necessary changes to accelerate the rebalancing of the service system. The status quo is no longer an option given demographic trends, rising health care costs and state and federal budget problems, rather, new ways of thinking, new partnerships and different funding sources will need to be utilized.

A major focus for rebalancing the dollars available will be to identify necessary family supports in order to enable some people to continue to live at home with their families and other people to move to more independent community settings. The department is also working collaboratively with Office of Rehabilitative Services and the Department of Labor and Training to identify additional strategies to assist more individuals with disabilities to access jobs in the community or other meaningful community participation.

Health and safety of each person is the primary priority and collaborative planning with community agencies to align resources, learn new ways to support people in local communities and build in the necessary requirements to adhere to person centered practices, quality and accountability.

Appendix V
Principles of the Patient-Centered Medical Home

Description

The major primary care professional societies[1] developed principles for the PC-MH in March 2007.

Principles

Personal physician - each patient has an ongoing relationship with a personal primary care physician (PCP).
Physician directed medical practice – the PCP leads a team of individuals within their practice who collectively take responsibility for the ongoing care of the person.
Whole person orientation – the PCP is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their PCP, and practice staff.

Payment should appropriately recognize the added value provided to patients who have a patient-centered medical home.

Appendix VI

Rhode Island
Global Consumer Choice Compact Demonstration
Redesigning Medicaid for the Future
CMS Template

Program Title and General Program Summary

Rhode Island's Medicaid reform proposal provides the framework for providing high quality and cost effective services that builds upon the positive gains made in the program over the last ten years and extends their reach further. From the administrative and financing perspective, the proposal presented here seeks to establish a new state-federal compact that provides flexibility in exchange for federal budgetary certainty. This compact will provide Rhode Island with the tools necessary to address beneficiary need in a holistic and person-centered manner, while providing the flexibility to adapt to change.

More specifically, under the proposed compact, Rhode Island will operate its entire Medicaid program under a single waiver demonstration over the next five years. All Medicaid funded services on the continuum of care – from preventative and acute to long-term and end-of life-care – will be organized, financed and delivered through the demonstration. Accordingly, Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, its 1915(b) Dental Waiver, and its various Section 1915(c) Home and Community Based Services waivers will become a part of the Global Consumer Choice Compact Demonstration. Additionally, on-going initiatives that further the Compact's principles will also be incorporated into the demonstration. For example, the State's Medicaid Transformation and CHOICES MMIS Module initiatives along with a statewide health information exchange under construction will provide strategic resources that will assist in implementation of the demonstration. The State's Real Choices grant and the Rhode Island Perry-Sullivan Act [6]of 2006 – both of which are targeted at long-term care system reform – will guide consumer and provider outreach and efforts to change existing service markets and build new ones.

II. Current Health Care Situation:

Please see Addendum II

III. Demonstration Design:

The Global Consumer Choice Compact Demonstration will be a collaborative, cross-departmental effort involving all the agencies within the Executive Office of Health and Human Services (EOHHS) as well as other portions of state government, the private sector and stakeholders. The responsibility for the administration of the waiver will be the Department of Human Services and EOHHS. The Department of Human Services will be responsible for the day-to-day management and for meeting all reporting requirements. The allotment will flow through the single state agency, which will distribute, through interagency agreements, contracts, or provider agreements, funds to each department within EOHHS.

The Rhode Island Global Consumer Choice Medicaid Waiver seeks to:

[6] The Perry/Sullivan Long-Term Care Service and Finance Reform Act (Chapter 40-8.9-Sections 1-6)

A. Rebalance the Long Term Care System

Rhode Island's long-term care system is heavily based on nursing home care, residential care, and high-end services. Through this change initiative, the State of Rhode Island proposes to rebalance the system in favor of community-based care by diverting prospective admissions and developing alternatives.

Specific activities related to this component of the Waiver Request are to:

1. Establish an inter-agency Assessment and Coordination Unit;
2. Replace the current single level of care definition within each 1915(c) Home and Community Based Waiver with a three-tier level of care determination process: highest, high, and preventive;
3. Limit access to institutional and high-end residential settings to individuals meeting the highest level of care;
4. Limit access to certain optional community based services to individuals at the high and preventive levels of care based on available funding;
5. Fund transitional services, such as security deposits; essential furnishings and moving expenses; set-up fees or deposits for utility or service access; and health and safety assurances;
6. Allow an income disregard for living expenses;
7. Expand Medicaid to certain at-risk populations on a limited basis in order to divert from institutionalization. For example, elderly individuals who need personal care services and are at risk for institutional placement but would not become eligible for Medicaid until after institutionalization.

B. Improve Access to and Quality of Acute, Primary, and Secondary Care through Improved Care Management

One of the central goals of the Global Consumer Choice Compact Demonstration is to shift the focus in the program to make it more "person-centered." In order to achieve this goal, each beneficiary will have a medical home that provides support in coordinating/managing services and assistance in system navigation. Beneficiaries will also be more active participants in decisions about their care and will have access to the information required to make reasoned care choices.

Specific activities related to this component of the Waiver Request are to:

1. Mandatory enroll Medicaid eligible adults into a managed care organization delivery system or a primary care case management option for primary and acute health care;
2. Mandatory enroll all children into a managed care organization delivery system and explore the development of an intensive primary care case management for all children;
3. Establish Healthy Choice Accounts in which beneficiaries are rewarded for engaging in targeted healthy behaviors;
4. Raise RIte Care premium rates for families that currently pay premiums and apply RIte Care premium rates for families with incomes at 133-150% FPL
5. Impose co-pays for RIte Care populations for inappropriate emergency department use and brand name prescription drugs;
6. Increase the accountability for the payment of RIte Care premiums;
7. Eliminate certain health benefits including dental, over the counter (OTC) drugs, and podiatry benefits for parents 100-185% FPL;

C. Implement Smart Purchasing

The way Rhode Island purchases Medicaid funded services must change to ensure every Medicaid dollar spent achieves the best health outcome. The model of value based or "smart" purchasing will be expanded so that increased competition can yield not only the best price, but also improved capacity and performance. Toward

this end, the State is committed to restructuring both how it purchases and pays for services, particularly on the long-term care side, to create new and better markets that address beneficiary needs.

Specific activities related to this component of the Waiver Request are to:
1. Selectively contract for inpatient psychiatric beds and selected outpatient services;
2. Review and revise prescription drug purchasing;

IV. Eligibility

Standard Eligibility Definitions

1. ***"Mandatory"*** *refers to those eligibility groups that a state must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of the Federal poverty level (FPL).*

Individuals in the Mandatory Populations will be included in this Demonstration.

2. ***"Optional State Plan Populations"*** *refers to populations that are covered under the Medicaid or SCHIP State Plan. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C.*

Individuals currently covered, as Optional Populations will be included in this Demonstration.

3**.** ***"Categorical Expansions"*** *refers to optional populations that could be covered under the Medicaid or SCHIP State Plan but are instead included as expansion populations under the Demonstration. Groups are considered optional if they <u>can be</u> included in the State Plan, regardless of whether they <u>are</u> included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C.*

Individuals currently covered, as "Categorical Expansions" under the 1115 RIte Care Demonstration will be included in this Demonstration.

4 ***"Non-Categorical Expansion Populations"*** *refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 demonstration authority. Examples include childless non-disabled adults under Medicaid.*

All individuals currently covered under the 1115 RIte Care Demonstration will be included in this Demonstration.

V. State Defined Eligibility for the State Plan and for the Demonstration

The State intends to include all current eligibility groups under this Demonstration.

VI. Delivery Systems: Describe the type of delivery systems to be used under the demonstration: The types may include, but are not limited to, managed care (MC), fee-for-service (FFS), primary care case management (PCCM), a connector model, and premium assistance (indirectly through access to employer sponsored insurance and directly through access to the individual market)

Primary and Acute Care		
	Health Plan	**PCCM**
Beneficiaries Served:		
• Children &Families • Children with Special Needs • Children in Substitute Care	• RIte Care Plans • RIte Share	Under Design – May include: • Connect Care Plus (for high cost cases)
• Elders • Adults with Disabilities	• Rhody Health Partners • PACE	• Connect Care Choice • Connect Care Plus (for high cost cases)
The dually eligible population (Medicare/Medicaid) will have the option to enroll in a Special Needs Plan or PACE		

Long-term Care	
Beneficiaries Served:	Assessment and Care Unit FFS or Self-Directed Option
• Children &Families • Children with Special Needs • Children in Substitute Care	
• Elders • Adults with Disabilities	
Enrollees in PACE will receive all services through PACE.	

VII. Benefits:

All benefits will be covered under the Demonstration. Any proposed benefit reduction or benefit expansion is explained more fully in the Concept Paper. The State intends to eliminate benefits for only one population: dental, over the counter (OTC) drugs, and podiatry benefits for parents with incomes at 100-185% FPL. In general, this Demonstration seeks to allow the State more flexibility in determining how institutional and high-end residential treatment settings are accessed. The State seeks to add some benefits, such as transitional services, to facilitate an individual's move back to the community.

VIII. Cost-sharing:

Cost sharing for enrollees in the current RIte Care program will remain the same and will be increased for certain populations. Please refer to the General Program Summary above.

IX. Population Estimates and Take-up Rates:

The State is in the process of completing this analysis.

X. Budget Data:

The State is in the process of completing this analysis.

XI. Other Resources: To be filled in as appropriate.

XII. Funding Questions: The State is in the process of completing the responses to the funding questions.

Addendum 1

In SFY 2006, the Rhode Island's Medicaid program provided health coverage and services to about 227,000 Rhode Islanders at some point in time. The program encompasses a diverse array of beneficiaries, who qualify for services on the basis of age, income, and/or disability under one of the mandatory or optional coverage groups in Title XIX, or as SCHIP eligible children or parents under Title XXI. All Medicaid beneficiaries receive an equally broad range of services, again both mandatory and optional, through several different delivery mechanisms in the institutional or community-based setting.

The Rhode Island Medicaid program includes many different categories of eligibility based on one or more characteristic, nearly 80 percent of which are optional under Title XIX. Most of these optional groups consist of children and their parents with income above the levels established in Title XIX for mandatory coverage, who became eligible for Medicaid through the RIte Care waiver during a series of expansions in the mid to late 1990s. More recently, however, the trend has been to extend coverage via Section 1915(c) waivers to adults with disabilities and elders receiving care in the community who might otherwise only be eligible for full Medicaid State Plan services if they were cared for in the institutional setting.

A breakdown of the mandatory and optional groups covered under the Rhode Island Medicaid program is as follows:

Mandatory Coverage Groups -- Must be covered by all state Medicaid programs:

- Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI);
- Low-income Medicare beneficiaries;
- Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements
- Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
- Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
- Infants born to Medicaid-enrolled pregnant women; and
- Children who receive adoption assistance or who live in foster care, under a federally sponsored Title IV-E program.

Optional Coverage Groups – The state has chosen to cover these additional groups of individuals and families:

- Low-income elderly adults or adults with disabilities;
- Individuals eligible for Home and Community Based Services Waiver programs;
- Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through SCHIP;
- Individuals determined to be "medically needy" due to low income and resources or to large medical expenses;
- Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision); and
- Women eligible for the breast and cervical cancer program.

For the sake of simplicity, these coverage groups are typically organized into four Medicaid "populations" that share key eligibility characteristics: children and families, children with special health care needs, adults with disabilities, and elders. The distribution of beneficiaries into these groups is as follows:

- Children & Families – 70%
- Children with special health care needs – 6%
- Adults with disabilities – 14%
- Elders – 10%

Beneficiaries in each of these groups are provided services through managed care, traditional fee-for-service, or through a waiver program. Children and families are served through the state's Section 1115 managed care demonstration waiver, RIte Care and its sister premium assistance program, RIte Share. Children with special health care needs are served through RIte Care and fee-for-service. Adults with disabilities and elders receive Medicaid through either fee-for-service or one of the state's Section 1915(c) Home and Community Based Services (HCBS) waivers.

Addendum II Current Rhode Island Benefits **(Categorically and Medically Needy)**			
ACUTE CARE		**Products & Devices**	
Institutional/Clinical Services		Dentures	YES
Freestanding Ambulatory	YES	Eyeglasses	YES
Public Health/Mental Health Clinic	NO	Hearing Aids	YES
Federally Qualified Health Center	YES	Medical Equipment & Supplies	YES
Inpatient Hospital	YES	Prosthetic & Orthotic Devices	YES
Outpatient Hospital	YES	**Transportation Services**	
Rehab: Mental Health/Substance Abuse	YES	Ambulance	YES
Rural Health	NO	Non-Emergency Medical	YES
Practitioners		**Other Services**	
Certified Nurse Anesthetist	NO	Diagnostic, Screening, Preventive	YES
Chiropractor Services	NO	EPSDT	YES
Dental Services	YES	Extended Services for Pregnant Women	YES
Medical/Remedial Care	YES	Family Planning	YES
Dental Medical/Surgical	YES	Lab – X-Ray Outside a Clinic	YES
Nurse Midwife	YES	Target Case Management	YES
Nurse Practitioner	YES	**LONG-TERM CARE SERVICES**	
Optometrist	YES	**Community Based**	
Physician Services	YES	HCBS Waiver	YES
Podiatrist	YES	Home Health	YES
Psychologist	NO	Hospice	Yes
Prescription Drugs		Personal Care Services	NO
	YES	Private Duty Nursing	NO
Physical Therapy Services		PACE	YES
Occupational Therapy	NO	**Institutionally-Based**	
Physical Therapy	NO	Inpatient Hospital, Nursing Facility, ICF/MR >65	YES
Speech, Hearing & Language	NO	Inpatient Psychiatrist <21	YES
		ICF/MR	YES
		Nursing Facility	YES
		Religious Non-Medical Institution	NO

State Administration:

Addendum III Rhode Island Current Medicaid Purchased & Directly Provided Services by Department						
Population	**Department of Human Services**	**Department of Children, Youth & Families**	**Department of Mental Health, Retardation & Hospitals**	**Department of Elderly Affairs**	**Department of Health**	**Local Education Agencies**
Children & Families Managed Care	RIte Care Health Plans – Basic MA plus FFS for wrap around services; Comprehensive Evaluation, Diagnosis, Assessment Referral & Re-evaluation (CEDARR) Family Services	Certain Behavioral Health Services	Substance Abuse Treatment		State Laboratory	Case Management & School-Related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education Students
Children w/ Special Health Care Needs	Basic MA Services Thru Health Plans or Direct Pay to FFS Providers; Comprehensive Evaluation & Diagnosis	Residential Placement; Certain Behavioral Health Services	Substance Abuse Treatment		State Laboratory	Case Management & School-related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education Students
Adults w/ disabilities	Basic MA – FFS; Connect Care Choice – PCCM; Rhode Health Partners – Managed Care; HCBS Includes Assisted Living BCCTP		Behavioral Health Services to SPMIs'; Substance Abuse Treatment; CBS Service Includes DD/MR Adults; Slater Hospital	Assisted Living; Case Management; Assistive Technologies	Targeted Case Management for People with AIDS; State Laboratory	
Elderly Adults	Basic MA – FFS; Connect Care Choice – PCCM; Rhode Health Partners – Managed Care; HCBS Includes Assisted Living		Behavioral Health Services to SPMIs; Substance Abuse Treatment; CBS Service Includes DD/MR Adults; Slater Hospital	Home Health Services; Case Management; Home Delivered Meals; Assisted Living; Assistive Technology; Minor Home Modifications; Senior Companion Program	State Laboratory	